

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10746

10656

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> MARYLAND b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BESSIE ALBERTA ARNOLD</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 26 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 27 - 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARTINSBURG W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID STINE</u>				14. MOTHER'S MAIDEN NAME <u>CLARA BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. PEARL SWOPE</u> <u>BOONSBORO MD. R. 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with Fibrillation</u> <u>420.0</u> DUE TO <u>+ myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTERVAL BETWEEN ONSET AND DEATH</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Gangrenous Appendicitis - appendectomy - two weeks ago</u> (b) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9 Sept 1960</u> to <u>26 Sept 60</u> that (I) (we) last saw the deceased alive on <u>26 Sept 1960</u> and that death occurred at <u>230 P</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>F. F. Lusby</u>				22b. DATE SIGNED <u>27 Sept 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				22d. ADDRESS <u>230 N Potomac</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 30, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Baer</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 3 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

1

Received of the Secretary of the Interior
the sum of \$100.00 for the purchase of
land for the purpose of establishing
a reservation for the use of the
Department of the Interior.
The land is situated in the
County of ... State of ...
and is of the size of ...
acres. The land is to be used
for the purpose of ...
and is to be managed by the
Department of the Interior.

Very truly yours,
[Signature]
[Title]
Department of the Interior
Washington, D.C.

1

10804

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10657

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conococheague				c. LENGTH OF STAY IN 1b 8 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Floyd Bittle				4. DATE OF DEATH Month Day Year 9 24 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/1870	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner				10b. KIND OF BUSINESS OR INDUSTRY farm			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William Metzer Bittle				14. MOTHER'S MAIDEN NAME Catherine Routzahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
17. INFORMANT Address Mrs. Simon Summers, Middletown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO general arteriosclerosis with Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) asthenosclerotic heart disease DUE TO (c) 2 yrs							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral indirect inguinal hernia - partial strangulation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Aug 7 1960 to Sept 24 1960 , that (I) (we) last saw the deceased alive on Sept 23 1960 , and that death occurred on Sept 24 1960 at 4:50 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Ditt III				22b. DATE SIGNED 9/26/60			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditt III, MD				22d. ADDRESS 217 W. Washington St Hagers town, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/27/60		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Myersville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				25a. REC'D BY REGISTRAR DATE SEP 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

(M)

(I)

0

BP

10001

RECEIVED BY POST

10001

(M)

(1)

RECEIVED BY POST

RECEIVED BY POST

RECEIVED BY POST

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10731

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>524 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Bledsoe</u> Last <u></u>		d. STREET ADDRESS <u>1520 Mt. Royal Ave.</u>	
4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-09</u>
9. AGE (In years last birthday) <u>51 yrs.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William R. Hendershott</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hulsutta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT <u>University Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration of vomitus</u> 962X DUE TO <u>Cerebral Contusion + lacerations</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subarachnoid + Ch. Hemorrhage</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>17 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell down stairs</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>3-3-1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>J. E. W. Sutter</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. E. W. Sutter</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/23/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Enter - Rouzer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '60</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Hume</u>	

MEDICAL CERTIFICATION

2

3V

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

107-2

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Physical Examination		Mental Examination	
Autopsy		Toxicology		Microbiology	
Pathology		Radiology		Other	
Signature of Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10732

10748

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN TB 10 years 03							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rebecca Middle M. Last Blickenstaff				4. DATE OF DEATH Month 9 Day 25 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 7 Days 8	IF UNDER 24 HRS. Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael Kline				14. MOTHER'S MAIDEN NAME Mary Maugans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. George Bussard, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1960 , to Sept 24, 1960 , that I last saw the deceased alive on Sept 24, 1960 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John D. Turco		M.D. 302 W. POTOMAC ST		ADDRESS (Street, city or town, state) HAGERSTOWN, MD		DATE SIGNED 9/26/60	
PHYSICIAN'S NAME (Type) Dr. John Turco							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/28/60		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Wolfsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE SEP 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1074

(M)

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1950		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Burial		Name of Burial Place	
Jan 16, 1950		Catholics		St. Mary's	
Name of Informant		Relationship		Address	
John Doe		Son		123 Main St	
Signature of Informant		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Burial		Name of Burial Place	
Jan 16, 1950		Catholics		St. Mary's	

1074

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
10805
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10733

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghmanton rural		c. LENGTH OF STAY IN 1b 18 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghmanton rural	
3. NAME OF DECEASED (Type or print) First Nannie Middle May Last Bloyer		4. DATE OF DEATH Month 9 Day 11 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1882
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Clearspring, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Repp		14. MOTHER'S MAIDEN NAME Rose Ann Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-36-0765	
17. INFORMANT Mrs. Russell Carbaugh		Address Boonsboro, Md. RI	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Carbonic Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gravitation column (c) Gravitation column		INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 to Sept 11, 1960 , that (I) (we) last saw the deceased alive on 8-10-60 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE A. E. W. Kraiss		22b. DATE SIGNED 9/12/60	
22c. PHYSICIAN'S NAME (Type) A. E. W. Kraiss		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-14-60	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls		23d. LOCATION (City, town, or county) (State) Clearspring Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR SEP 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
TSM 9/59

1

10749

10734

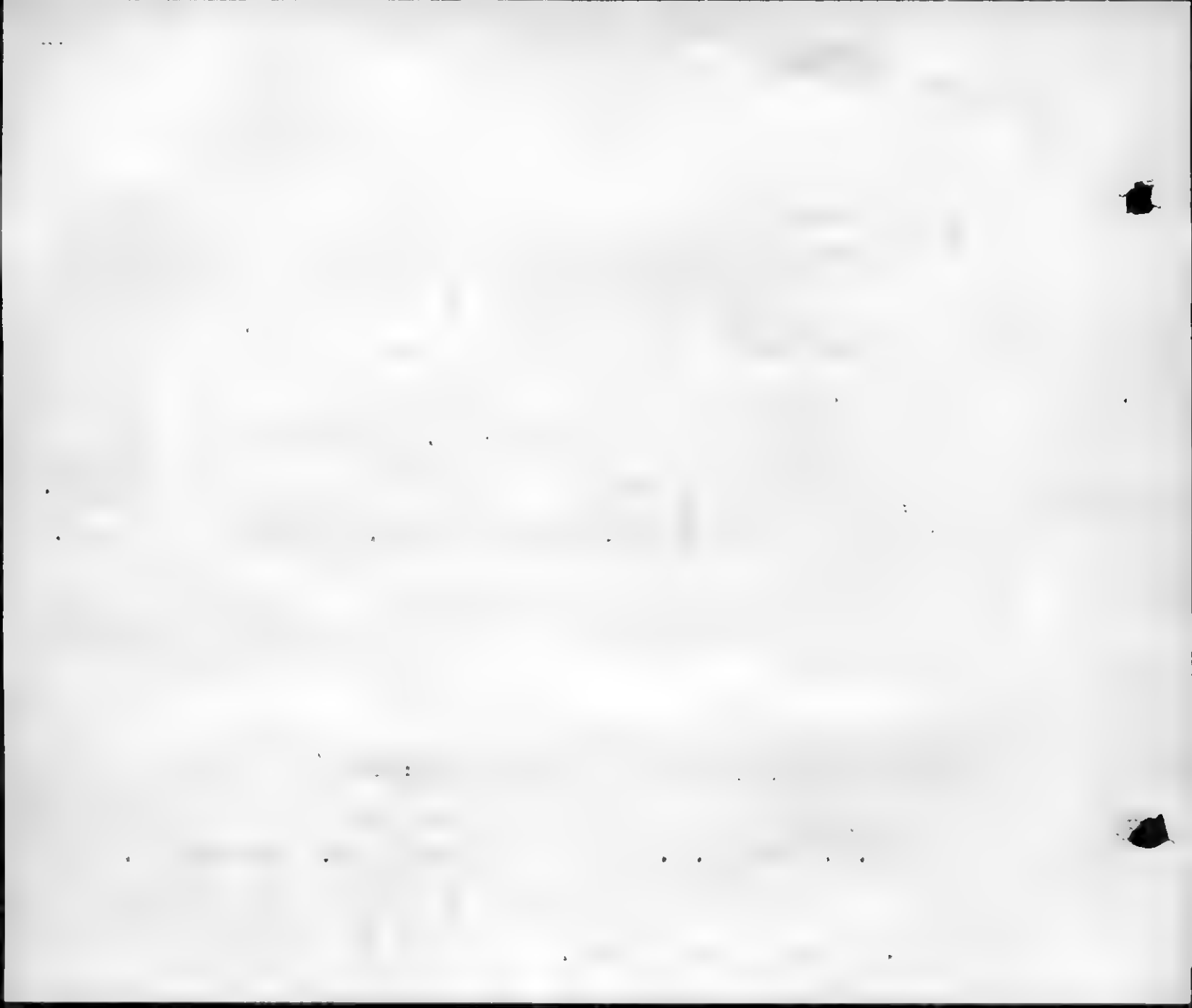
10749

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 1 d. STREET ADDRESS Mt Aetna e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MELVIN CHARLES BOHN		4. DATE OF DEATH Month September Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23 1899
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Operator Auto Salvage		10b. KIND OF BUSINESS OR INDUSTRY near Union Bridge Carroll Co	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles J. Bohn		14. MOTHER'S MAIDEN NAME Ursula Grossnickle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-6812	
17. INFORMANT Mrs Nina B. Bohn Hagerstown R # 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Urinary Bladder. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months. 5 years.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/13/56 to 9/20/60 , that (I) (we) last saw the deceased alive on 9/20/60 , and that death occurred at 4:30PM from the causes and on the date stated above.			
22a. SIGNATURE J. G. Warden, M. D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 832 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/60	
23c. NAME OF CEMETERY OR CREMATORY Beaver Dam Cemetery		23d. LOCATION (City, town, or county) (State) near Union Bridge Carroll Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE SEP 26 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

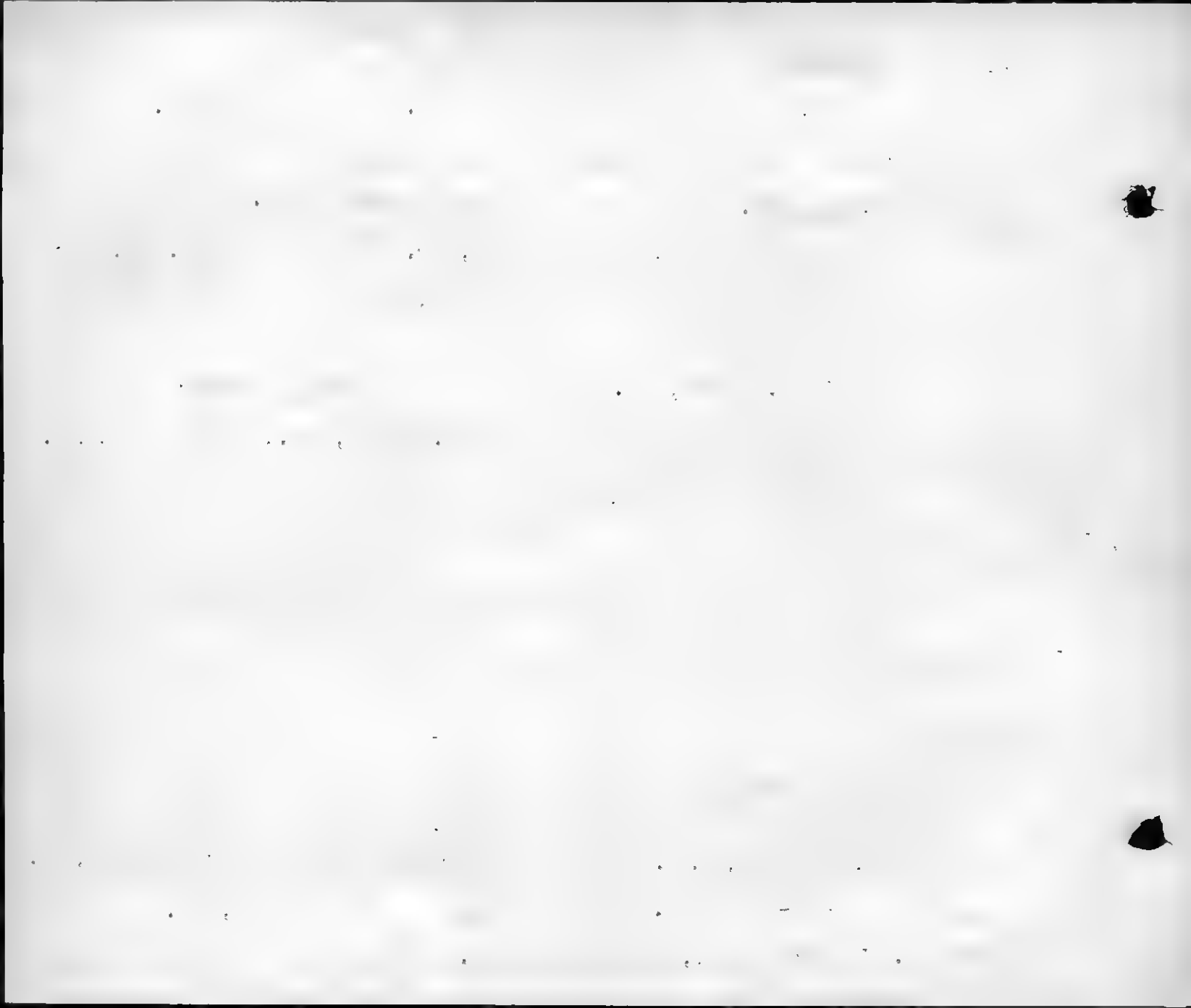
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10750

10735

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1415 Sherman Ave.		e. STREET ADDRESS 1415 Sherman Ave.	
3. NAME OF DECEASED (Type or print) First Melvin Middle Abraham Last Butts, Jr.		4. DATE OF DEATH Month Sept. Day 24 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1945
9. AGE (In years last birthday) yrs 15		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Melvin A. Butts, Sr.		14. MOTHER'S MAIDEN NAME Betty Semler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Melvin A. Butts, Sr., Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 193.0 DUE TO glaucoma & tumor of brain stem Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 Mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 22, 1960 to Sept 24, 1960 , that (I) (we) last saw the deceased alive on Sept 24, 1960 , and that death occurred at 3:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III		22b. DATE SIGNED 9/24/60	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington Street Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 9-27-60	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	23d. LOCATION (City, town, or county) (State) Sharpsburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

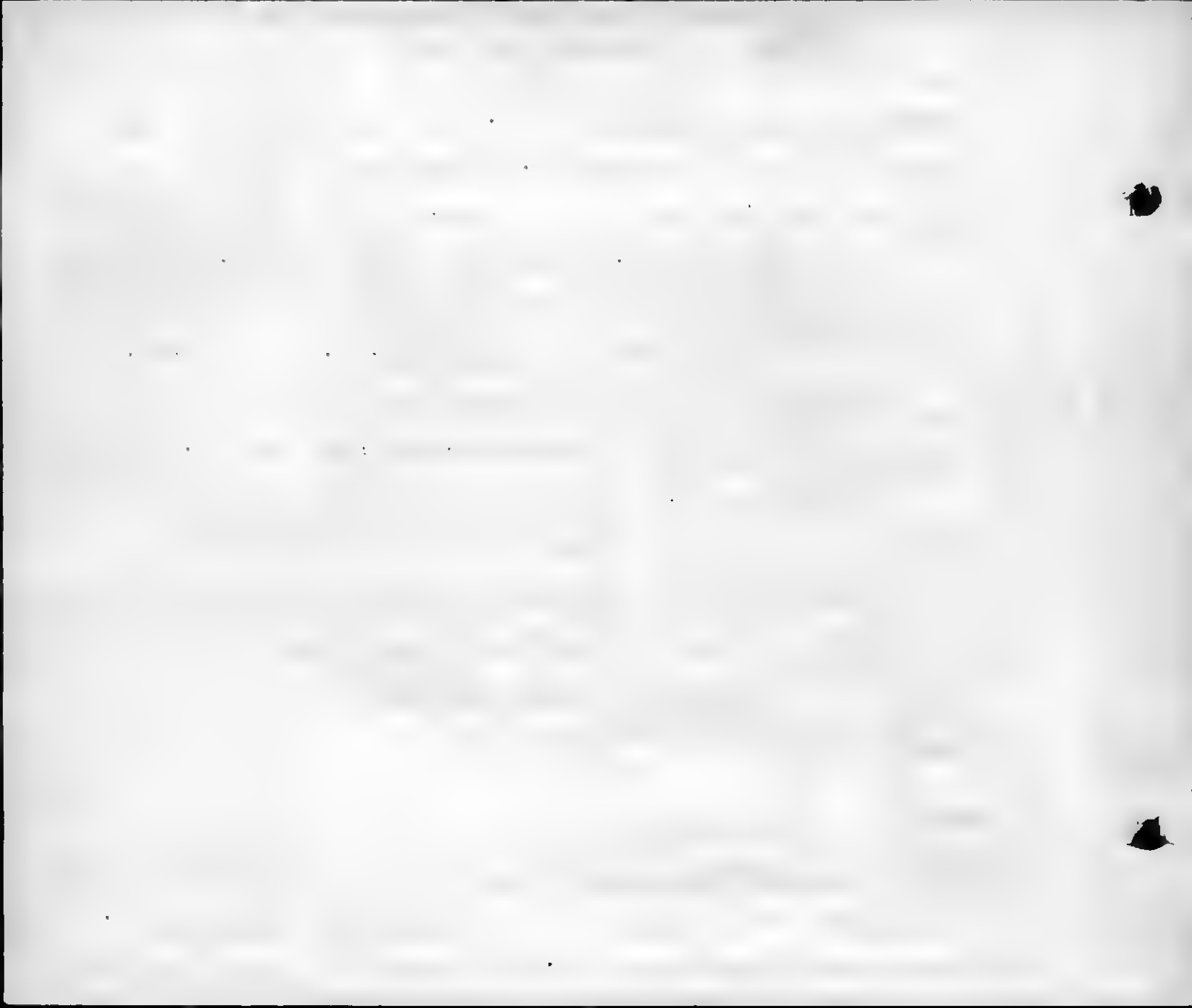


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 *Red 9/16/60*
10751 CERTIFICATE OF DEATH 10736
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>P.O. Box 49</u>	
3. NAME OF DECEASED (Type or print) First <u>Darell</u> Middle <u>E.</u> Last <u>Carbaugh</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/60</u>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Orrin Lee Carbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Faye Marie Helman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Orrin Lee Carbaugh, Shady Grove Pa. Box 49</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRE-MATURE SEPARATION OF PLACENTA</u> 234/60-- DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 Sept. 1960</u> to <u>29 Sept. 1960</u> , that I last saw the deceased alive on <u>29 Sept. 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>B. Lee Carbaugh</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 5 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>			

2081191XV0

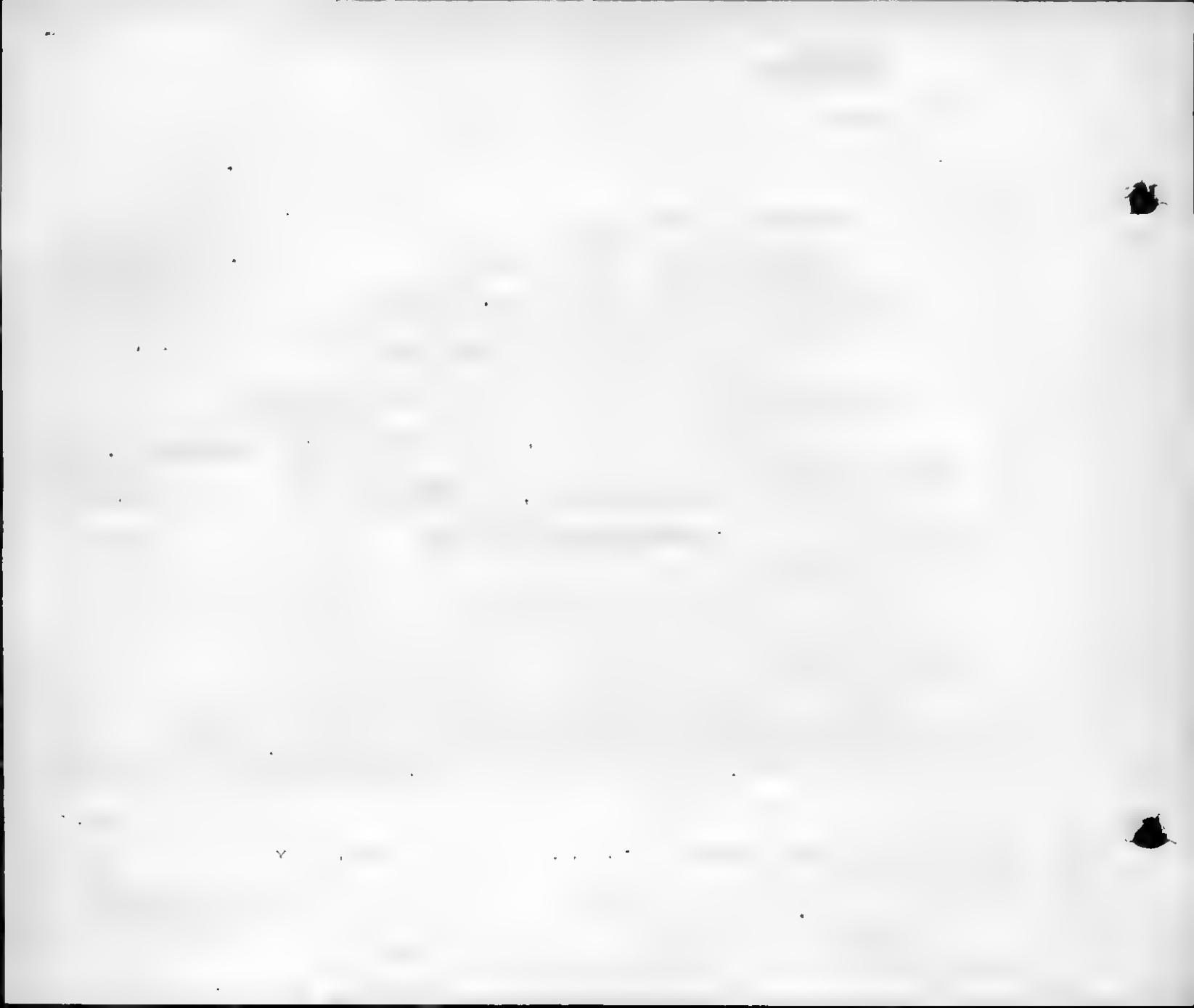


VR A15 (4)
ISM 9/59

(I

10737

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport Md. RFD #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Rural Williamsport RFD #2			
3. NAME OF DECEASED (Type or print) First Granton Middle Charlton Last Charlton				4. DATE OF DEATH Month Sept. Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12 1900		9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months 8 Days 6	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Harrisburg Va		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Casper Charlton				14. MOTHER'S MAIDEN NAME Mattie Keplinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217 10 2889		17. INFORMANT Mrs. May Charlton Williamsport Md. Address RFD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 113X IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED DUE TO CARCINOMA OF THE LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month Day 19 Year p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 16 1960 to SEPT. 19 1960 , that (I) (we) last saw the deceased alive on SEPT. 19 1960 , and that death occurred at 7:25 AM from the causes and on the date stated above							
22a. SIGNATURE Archie Robert Cohen				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED SEPT. 20,	
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.				22d. ADDRESS CLEAR SPRING, MARYLAND			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21-60		23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.				25a. REC'D BY REGISTRAR DATE SEP 21 '60		25b. REGISTRAR'S SIGNATURE William S. Frank	



CERTIFICATE OF DEATH

10739

10753

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b most of life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 144 Madison Ave.			
3. NAME OF DECEASED (Type or print) First Harvey Middle Clinton Last CLINE				4. DATE OF DEATH Month 9 Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1884		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Restraunt		11. BIRTHPLACE (State or foreign country) Battletown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Cline				14. MOTHER'S MAIDEN NAME Laura Bavey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Emma Cline		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of femur Lobular pneumonia generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Injury sustained following fall.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month July Day 7 Year 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Hagerstown				20g. (County) wash.		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Aug. 11, 1960 to Sept. 3, 1960 that (I) (we) last saw the deceased alive on Sept. 3, 1960 and that death occurred at 7:30 PM , from the causes and on the date stated above							
22a. SIGNATURE Young E. Chun				22b. DATE SIGNED Sept. 3, 1960		22c. PHYSICIAN'S NAME (Type) Young E. Chun	
22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/6/1960		23c. NAME OF CEMETERY OR CREMATORY Lutheran Church Cemetery		23d. LOCATION (City, town, or county) (State) Leitersburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Dean Hornberger				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 6 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

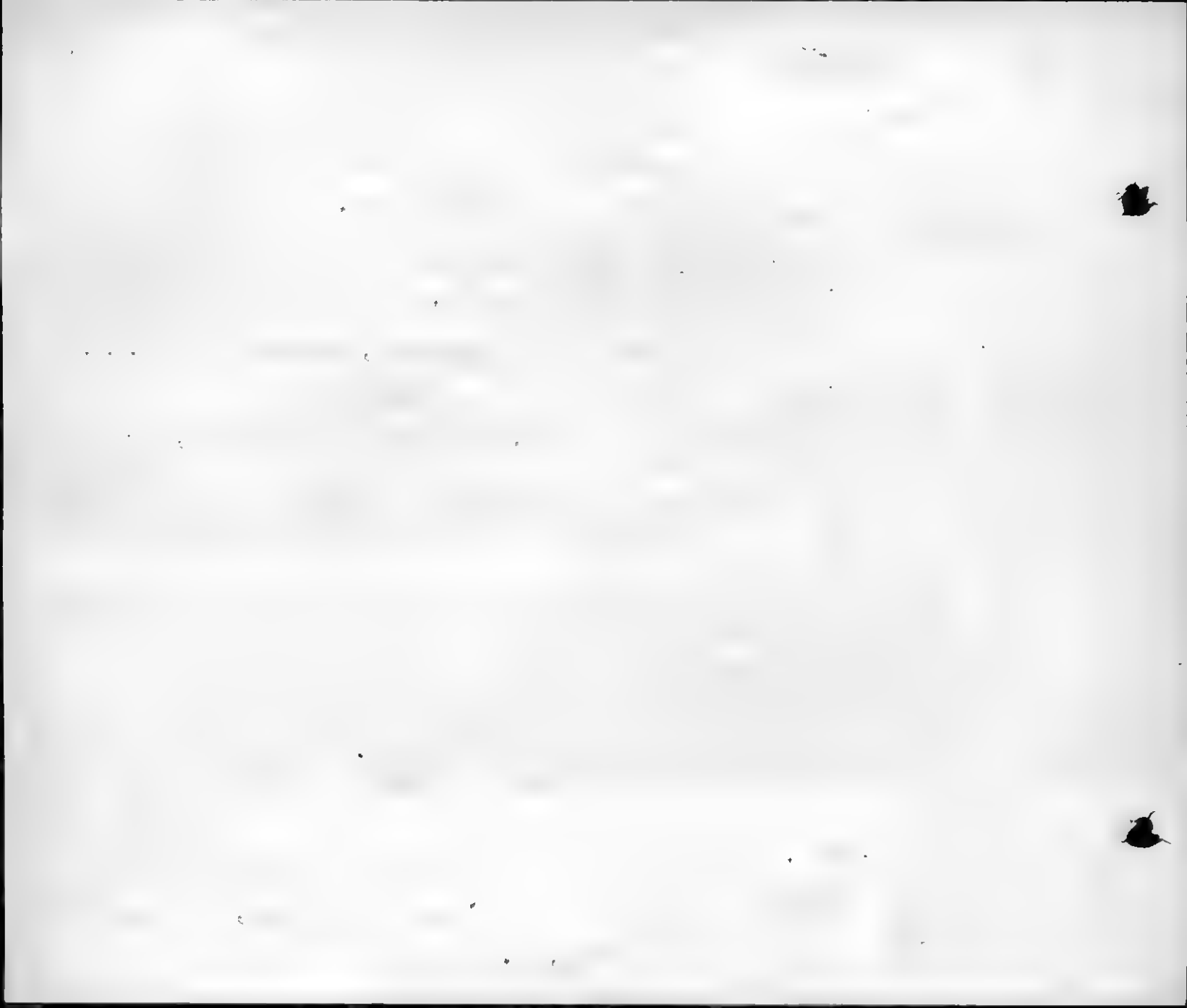
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be reissued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10806

10740

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 2, CLEAR SPRING, MD. c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESIDENCE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 2, CLEAR SPRING, MD. d. STREET ADDRESS ROUTE 2, CLEAR SPRING, MD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE First DAVID Middle CLOPPER Last				4. DATE OF DEATH Month SEPT. Day 17 Year 1960			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 6, 1885		9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) SELF EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (State or foreign country) BLAIRS VALLEY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HENRY CLOPPER				14. MOTHER'S MAIDEN NAME MARTHA ELLEN BARNHART			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT MRS LOTY V. CLOPPER		Address ROUTE 2, CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420. Coronary artery occlusion with myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH one hour one year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible Gastric Malignancy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 25, 1960 to September 17, 1960 , that (I) (we) last saw the deceased alive on Sept. 17, 1960 and that death occurred at 3:10 AM from the causes and on the date stated above.							
22a. SIGNATURE Archie Robert Cohen				22b. DATE SIGNED Sept. 18, 1960		22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	
22d. ADDRESS Clear Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept. 19, 1960		23c. NAME OF CEMETERY OR CREMATORY BLAIRS VALLEY CE.		23d. LOCATION (City, town, or county) (State) BLAIRS VALLEY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John P. Clark				25a. REC'D BY REGISTRAR SEP 21 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

M

I

O

MEDICAL CERTIFICATION



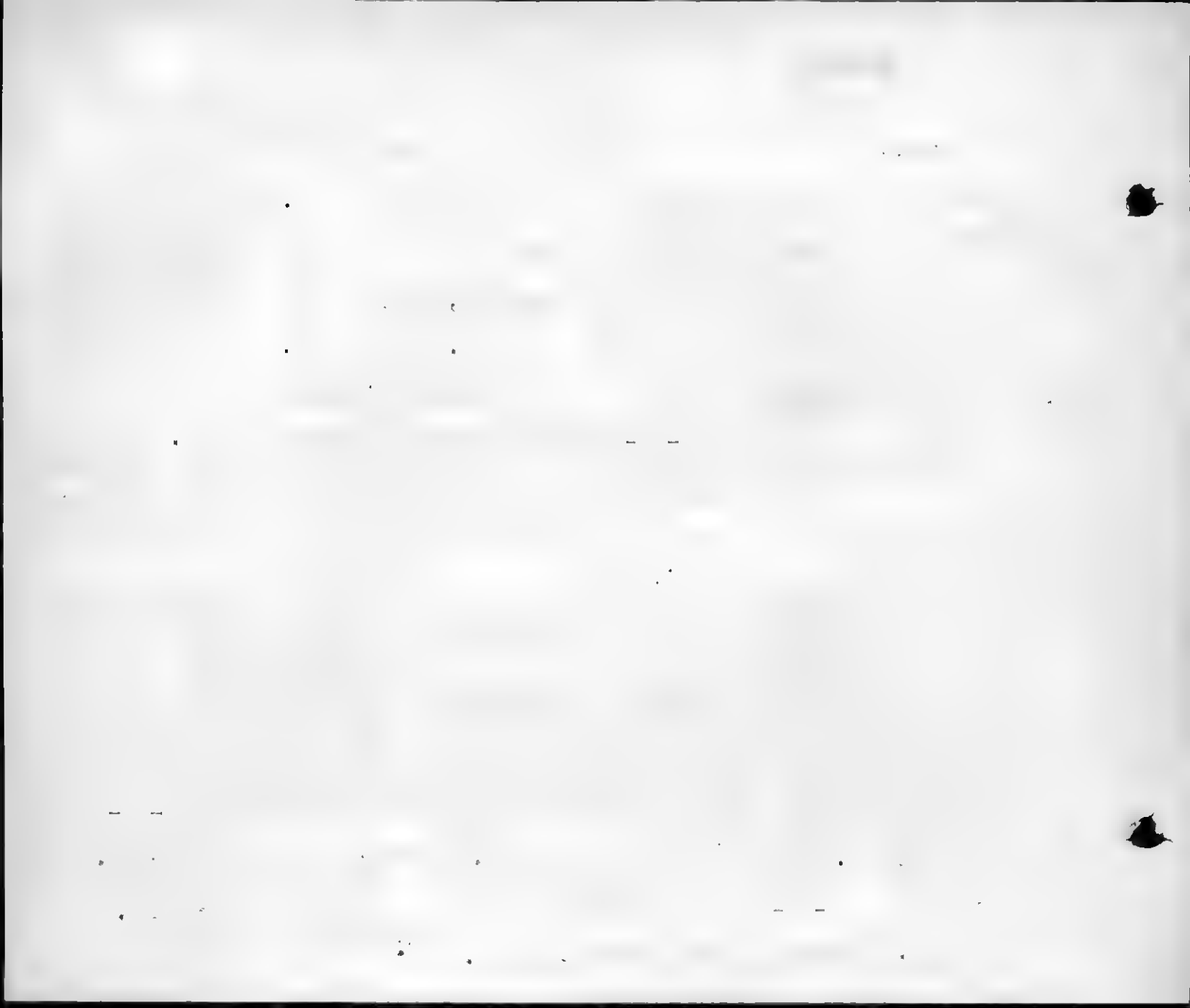
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10741

10754

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 14 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. STREET ADDRESS 1500 Northern Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lorene Lillian Colyer				4. DATE OF DEATH September 16 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1929	
9. AGE (In years last birthday) 31 yrs		10. IF UNDER 1 YEAR: Months 31 Days 16 Hours 19 Min 60		11. AGE (In years last birthday) 31 yrs		12. IF UNDER 24 HRS: Months 31 Days 16 Hours 19 Min 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) St. Louis Mo.	
13. FATHER'S NAME John Buller				14. MOTHER'S MAIDEN NAME Irene Viehman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 491-26-0218		17. INFORMANT Robert Colyer Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Ca of endometrium with metastases (generalized) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) metastases (generalized)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 wks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1960 Hour a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1959 to 16 Sept 1960 that (I) (we) last saw the deceased alive on 16 Sept 1960 and that death occurred at 1:00 M. from the causes and on the date stated above							
22a. SIGNATURE Harold H. Gist				22b. DATE SIGNED 9-17-60			
22c. PHYSICIAN'S NAME (Type) Harold H. Gist				22d. ADDRESS N. Potomac St Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-18-60		23c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		23d. LOCATION (City, town, or county) (State) Creve Coer Mo.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR SEP 19 60			
ADDRESS Hagerstown Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Arnold			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

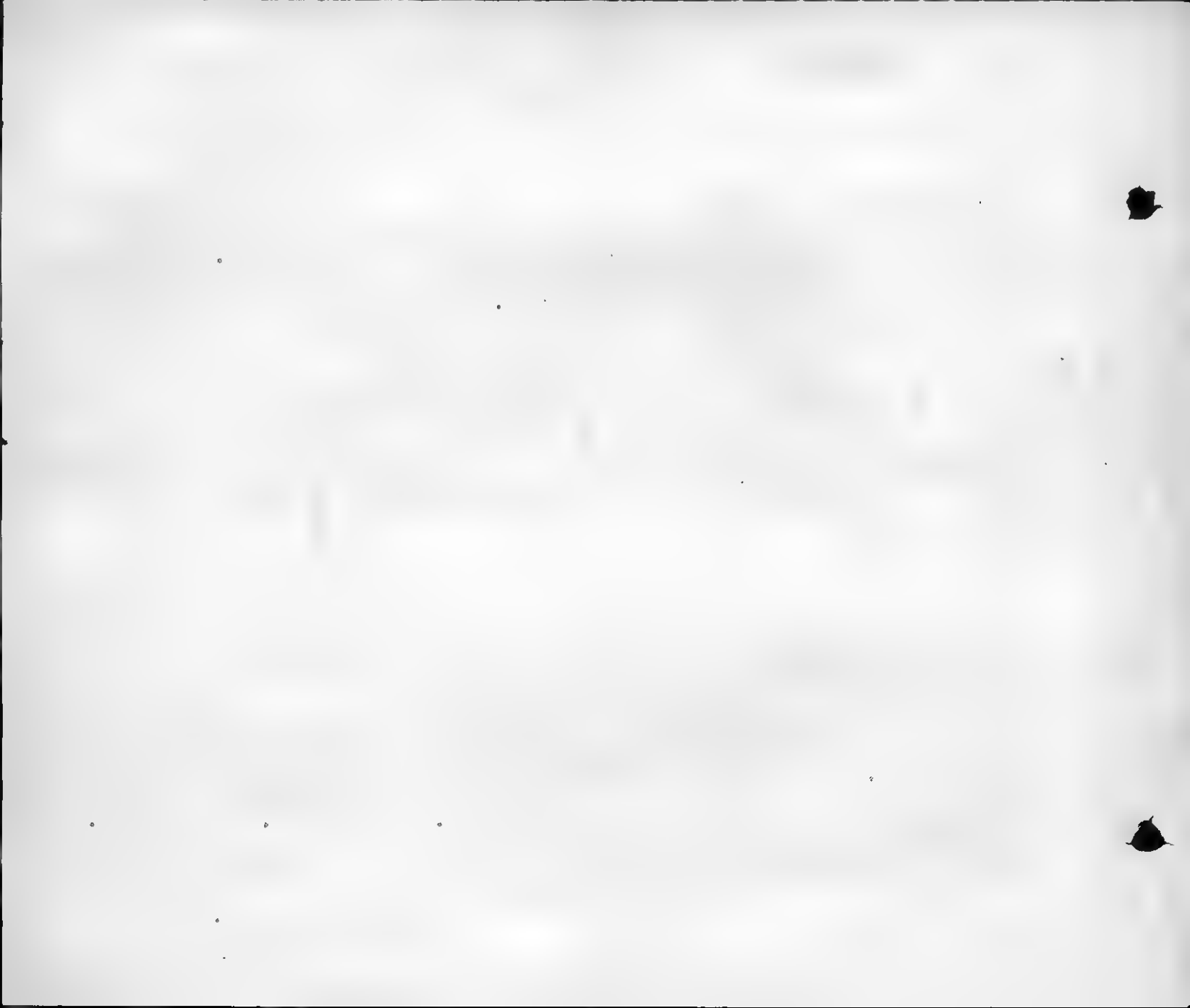
CERTIFICATE OF DEATH

Reg. Dist. No.

10799

10755

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>--</u>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Ann</u> Last <u>Witmer</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1960</u>
9. AGE (In years lost birthday) yrs. <u>20</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Clifton Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Viola Witmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apnea due to delay in delivering after coming head (Breech presentation).</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 7, 1960</u> , to <u>Sept. 7, 1960</u> , that I last saw the deceased alive on <u>Sept. 7, 1960</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>F.F. Lusby</u> M.D. <u>Dr. F.F. Lusby, 230 N. Pot. St., Hag., Md.</u> PHYSICIAN'S NAME (Type) <u>F.F. Lusby</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Co. Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.F. Lusby M.D.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

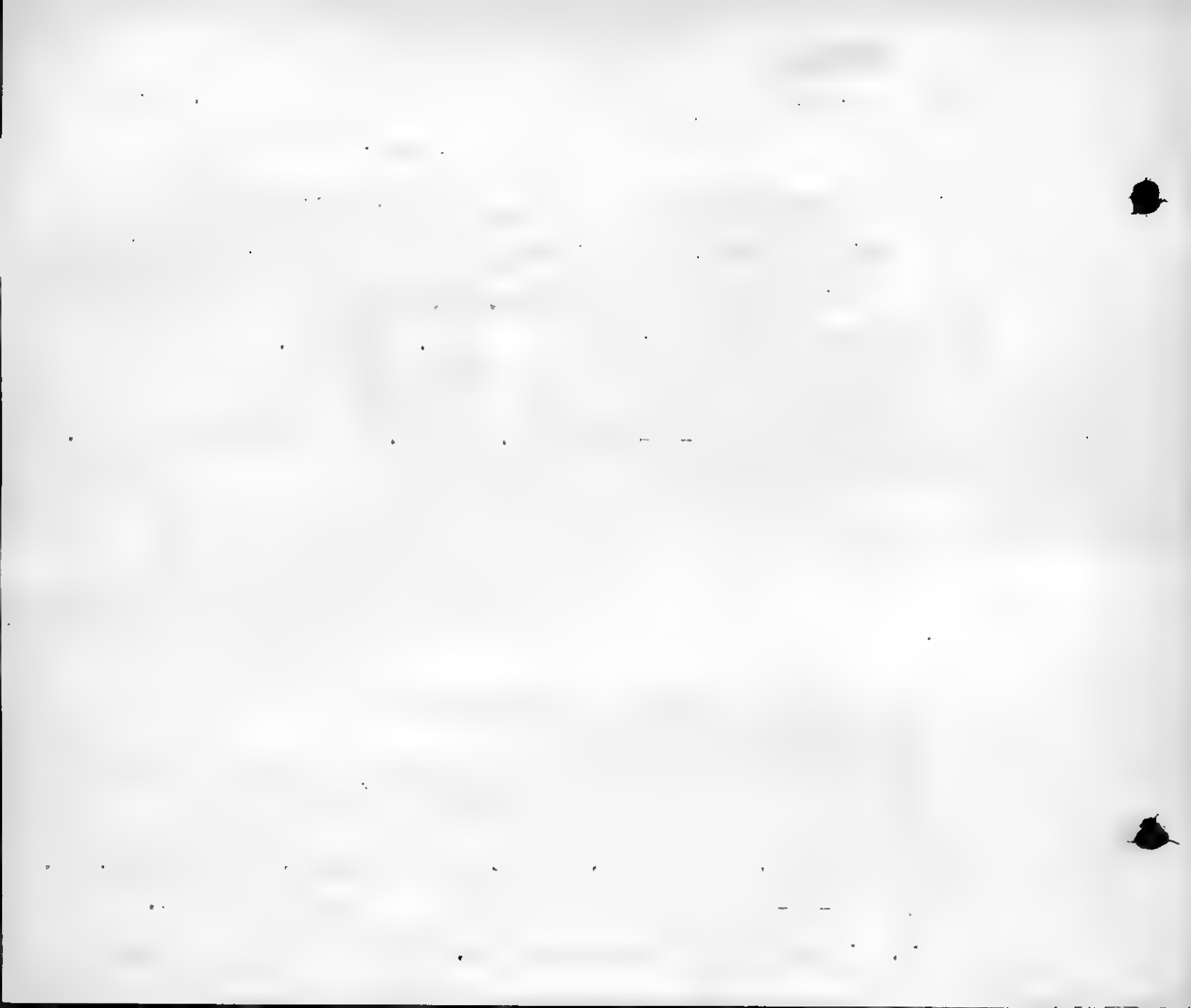
1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10742

10756

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 1/2 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 380 Belvedere Road	
3. NAME OF DECEASED (Type or print) Lewis Llewellyn Cross		4. DATE OF DEATH September 20 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1894
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Master		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) St. James Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lewis Cross		14. MOTHER'S MAIDEN NAME Llewella Clagett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-5285	
17. INFORMANT Mrs. Mary K. Cross		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease DUE TO (b) 7-30-60 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 13 yrs 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year April 1954 Hour o m p m 9-20		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1954 to 9-20 , 1960, that (I) (we) last saw the deceased alive on 8-20 , 1960, and that death occurred at 8:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welty		22b. DATE SIGNED 9-21-60	
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-23-60	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR SEP 26 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

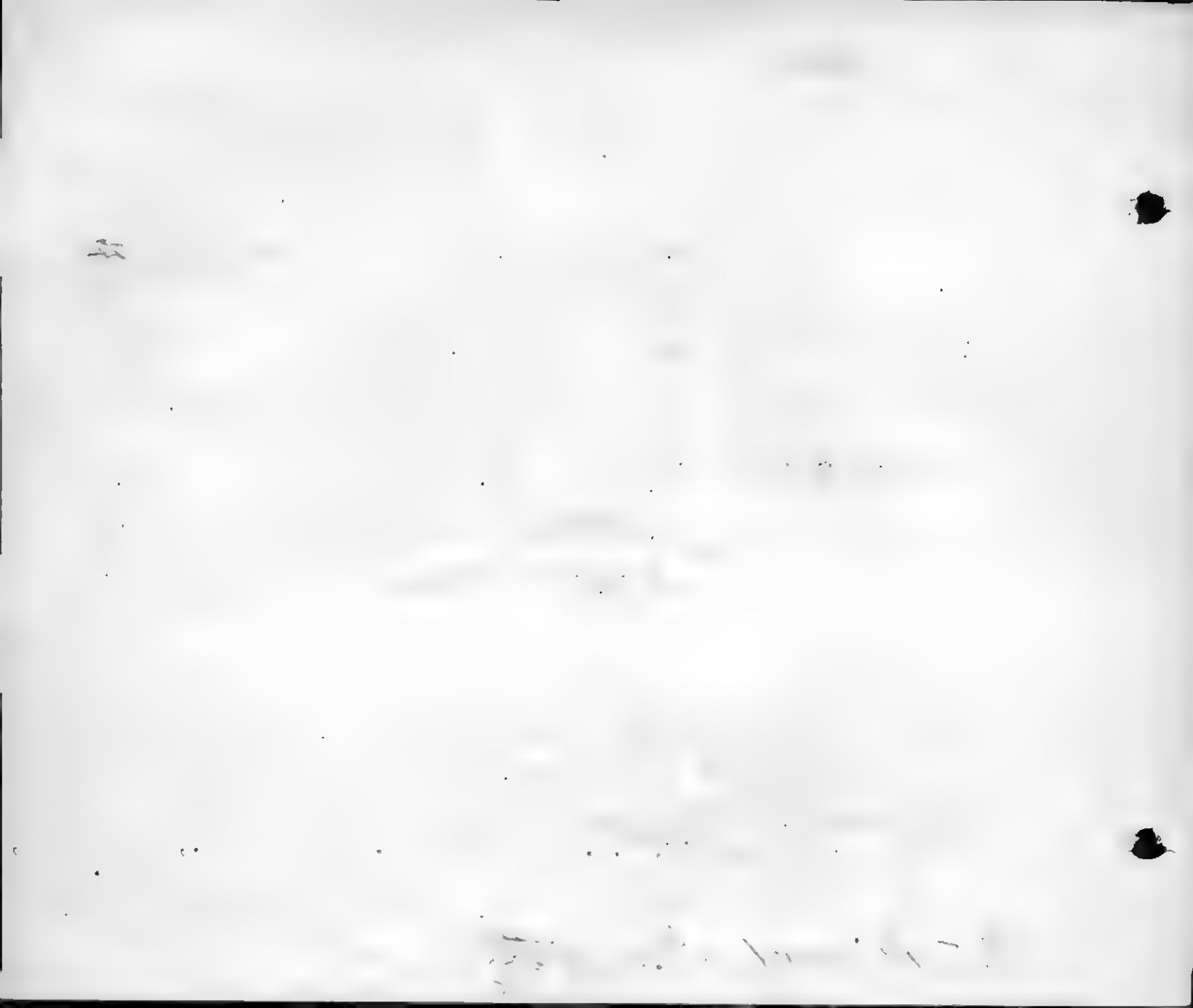


TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in the event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
10757
M
1
10743
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY FRANKLIN ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 9 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) MARTIN MANOR REST HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle LUSETTA Last DALEY		4. DATE OF DEATH Month SEPTEMBER Day 22 Year 1960	
5. SEX FEMALE	6. CO. OR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/1887
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min 00	11. IF UNDER 24 HRS Hours 15 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SCHENEBECK		14. MOTHER'S MAIDEN NAME ANNIE BARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, state in which service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT GEORGE SHATZER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.D. IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior cerebral artery Hypertension DUE TO (c) Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 9/22 19 56 to 9/22 19 60 , that (I) (we) last saw the deceased alive on 9/22 19 60 , and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Graff, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Louis G. Graff, M.D.		22d. ADDRESS 119 E. Antietam St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/25/60	
23c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL U.B. CHURCH		23d. LOCATION (City, town, or county) (State) COSEYTOWN PENNA.	
24. FUNERAL DIRECTOR'S SIGNATURE A. E. Minnich		25a. REC'D BY REGISTRAR SEP 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

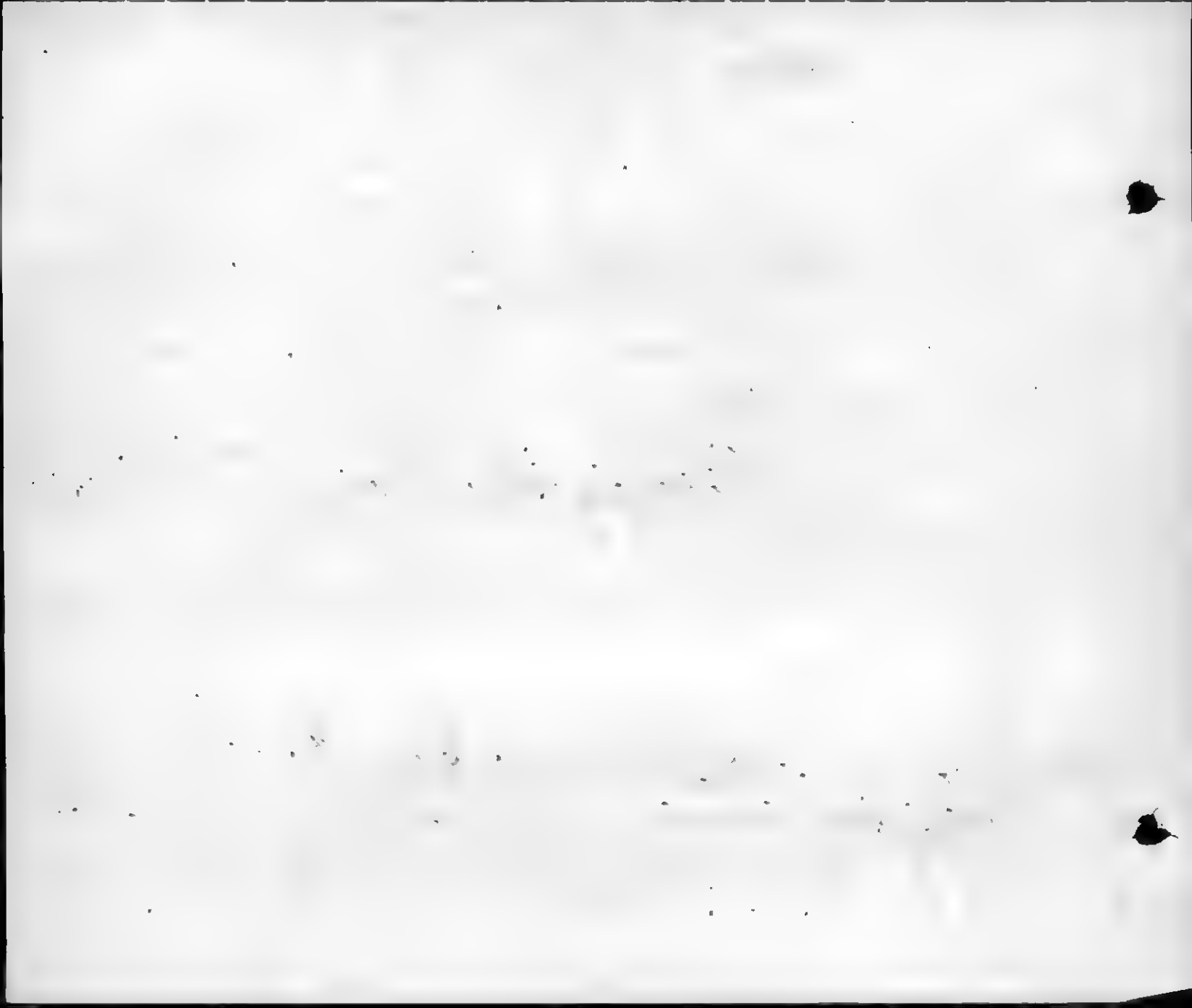
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10744

10758

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piper Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Almeda Last Davis				4. DATE OF DEATH Month Sept. Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15 1882	
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months 11 Days 0 Hours Min 		IF UNDER 24 HRS. Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Williamsport Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Cornelius Davis				14. MOTHER'S MAIDEN NAME Catherine Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215 019847		17. INFORMANT Mrs. Clyde Fleagle Address Piper Lane Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 20-1 DUE TO Copiously Thrown Back Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Substate (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				(County) 		(State) 	
21. I certify that (I) (this hospital) attended the deceased from 9/15/60 to 9/15/60 , that (I) (we) last saw the deceased alive on 9/15/60 , and that death occurred on 9/15/60 M, from the causes and on the date stated above							
22a. SIGNATURE Edith V. Lef Williamsport				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/16/60	
22c. PHYSICIAN'S NAME (Type) 				22d. ADDRESS 			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 17-60		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edith V. Lef Williamsport				25a. REC'D BY REGISTRAR DATE SEP 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

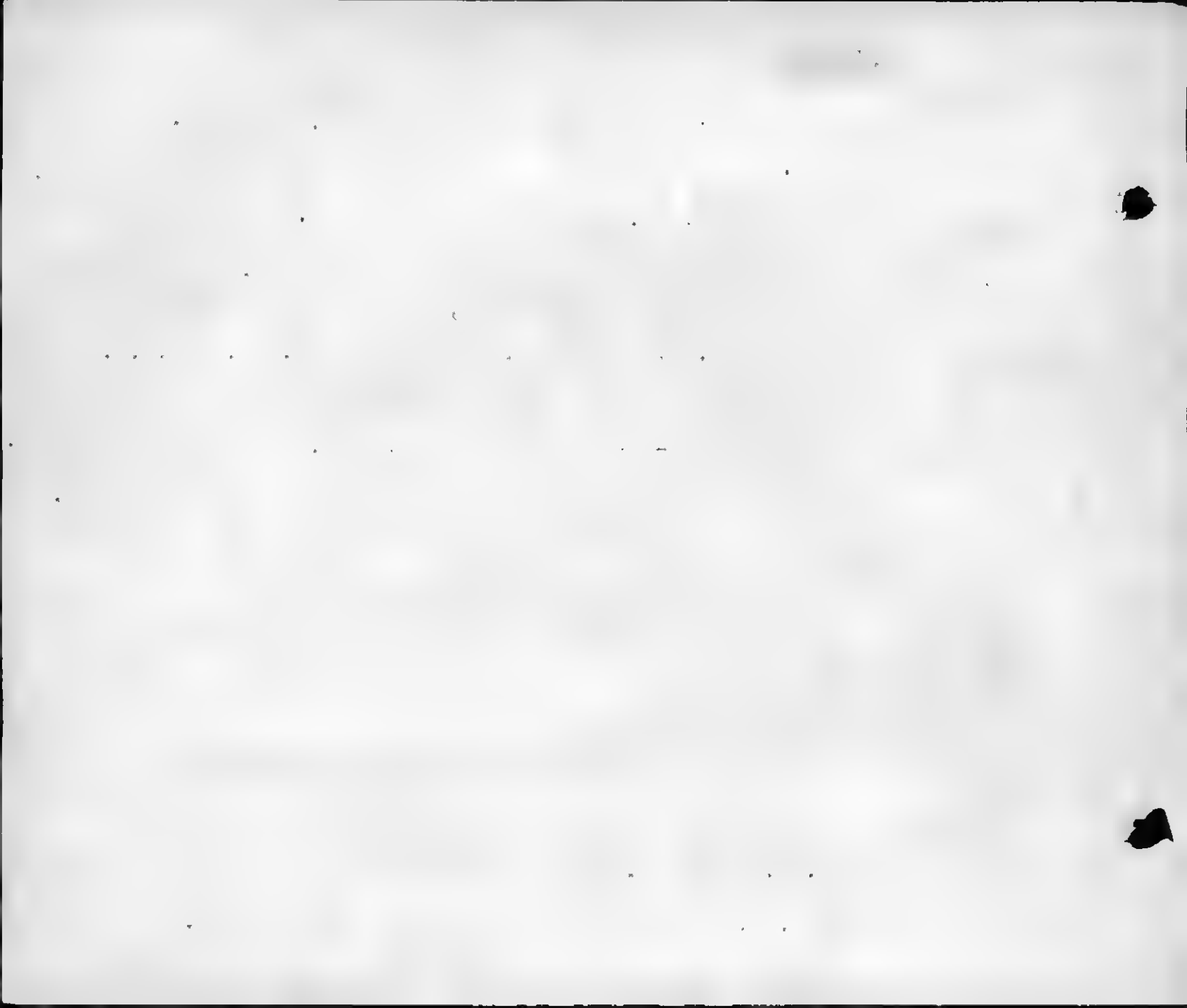
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10745

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BIG SPRING, MD. c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 1 BIG SPRING, MD.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ALIIQUIPPE PA. b. COUNTY BEAVER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ALIIQUIPPE d. STREET ADDRESS 308 FRANKLIN AVE., 75X e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM LLOYD DAVIS		4. DATE OF DEATH Month SEPT. Day 5 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1900
9. AGE (in years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATER TENDER		10b. KIND OF BUSINESS OR INDUSTRY J.&L. STEELE CO. WASHINGTON CO. MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK DAVIS		14. MOTHER'S MAIDEN NAME CATHERINE MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 162-16-3029	
17. INFORMANT MRS WILLIAM L. DAVIS, ALIIQUIPPE, PA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUODENAL ULCER DUE TO (c) RECENT INTERVAL BETWEEN ONSET AND DEATH 3 HRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. g. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. E. W. Ditto Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DR. E. W. DITTO JR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/6/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY PENNSYLVANIA MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) ROCHESTER PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Koster		24a. REC'D BY REGISTRAR SEP 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

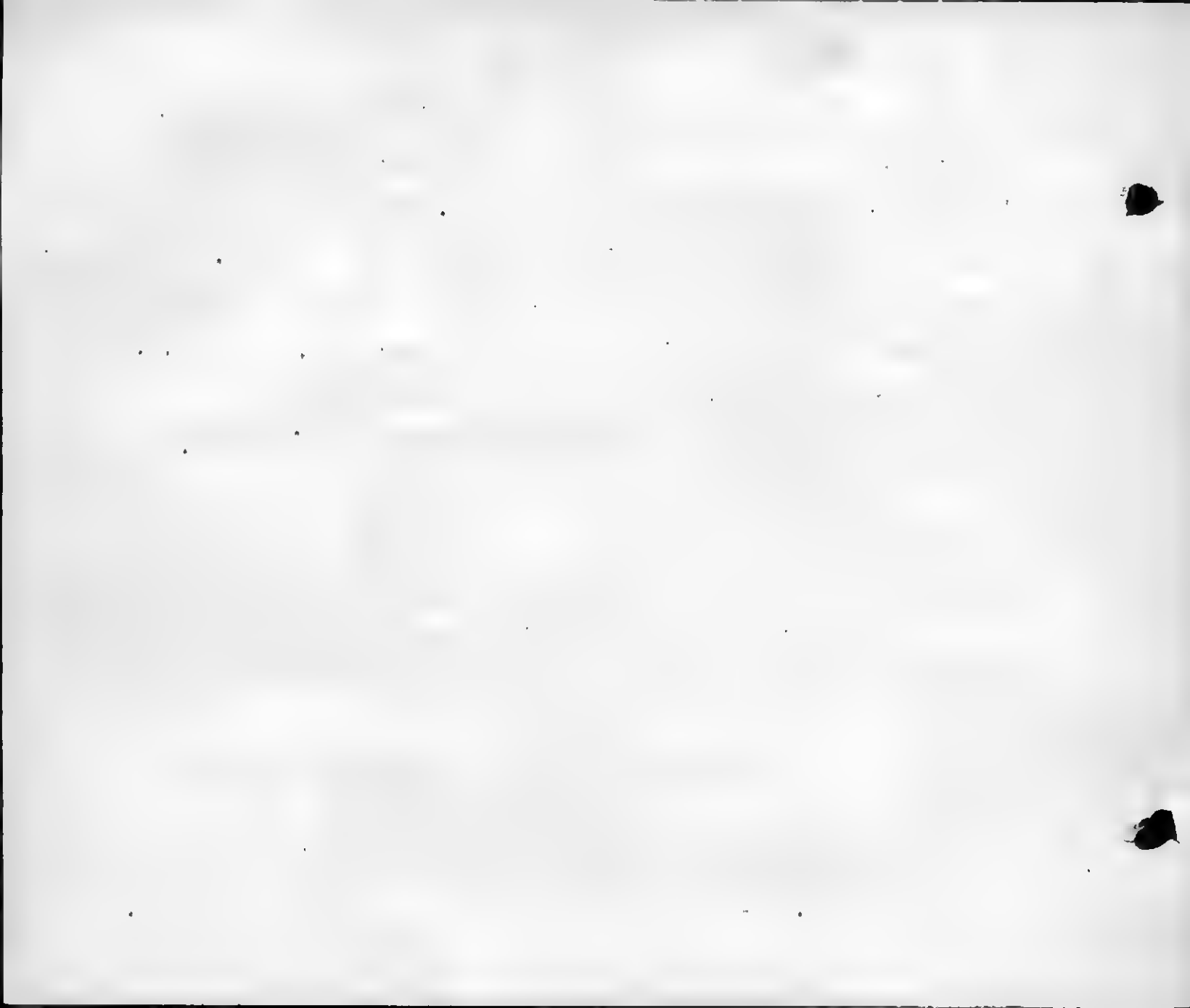
VR A15 (4)
15M 9/59

10759

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10746

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>311 W. Main Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucy Caroline Ditto</u>		4. DATE OF DEATH Month Day Year <u>Sept. 10 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <u>5 18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Lee Grayson</u>		14. MOTHER'S MAIDEN NAME <u>Selma Morland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown; If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 38 7662</u>	
17. INFORMANT <u>John Grayson</u>		Address <u>311 W. Main Street Sharpsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Left Femoral Thrombosis</u> DUE TO (c) <u>Generalized Abdominal Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 mos.</u> <u>2 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SCIRRHUS CARCINOMA OF SIGMOID COLON</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1960</u> , to <u>Sept. 10, 1960</u> that (I) first last saw the deceased alive on <u>Sept. 10, 1960</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John A. Moran M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN M.D.</u>		22d. ADDRESS <u>215 W. WASHINGTON ST. HAG, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mumma Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Sharpsburg Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Willemson, Md</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>	
ADDRESS <u>Albert Leaf Willemson, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

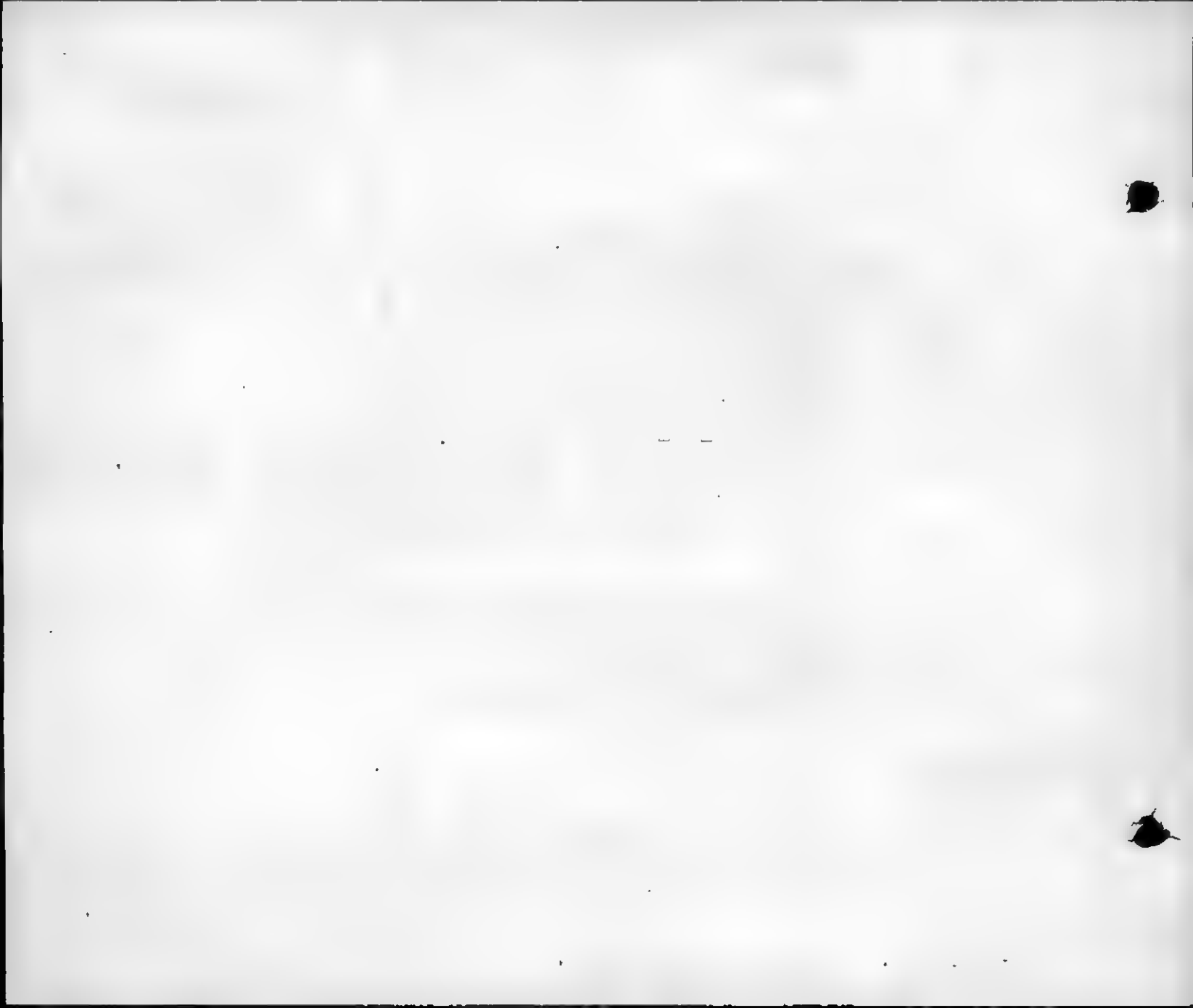
VR A15 (4)
15M 9/59

10760

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

10747

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS 348 No Mulberry St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JESSE First RAYMOND Middle EICHELBERGER Last				4. DATE OF DEATH Sept 11 1960 Month 11 Day 19 Year			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Md Ribbon Co				10b. KIND OF BUSINESS OR INDUSTRY Millstone Wash Co Md		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Eichelberger				14. MOTHER'S MAIDEN NAME Katherine McAllister			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-09-6780		17. INFORMANT Harold E. Eichelberger		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 293x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A plastic anemia DUE TO (c)				19. INTERVAL BETWEEN ONSET AND DEATH 4 days 15 m. 24 h			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 248 No Mulberry St Hagerstown Md.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7 Sept 1960 to 11 Sept 1960 , that (I) (we) last saw the deceased alive on 11 Sept 1960 , and that death occurred at 11 Sept 1960 M, from the causes and on the date stated above.							
22a. SIGNATURE Edson S. Hoachlander M D				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/12/60	
22c. PHYSICIAN'S NAME (Type) Edson S. Hoachlander				22d. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/14/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR SEP 15 '60	
25b. REGISTRAR'S SIGNATURE William S. Kraus							



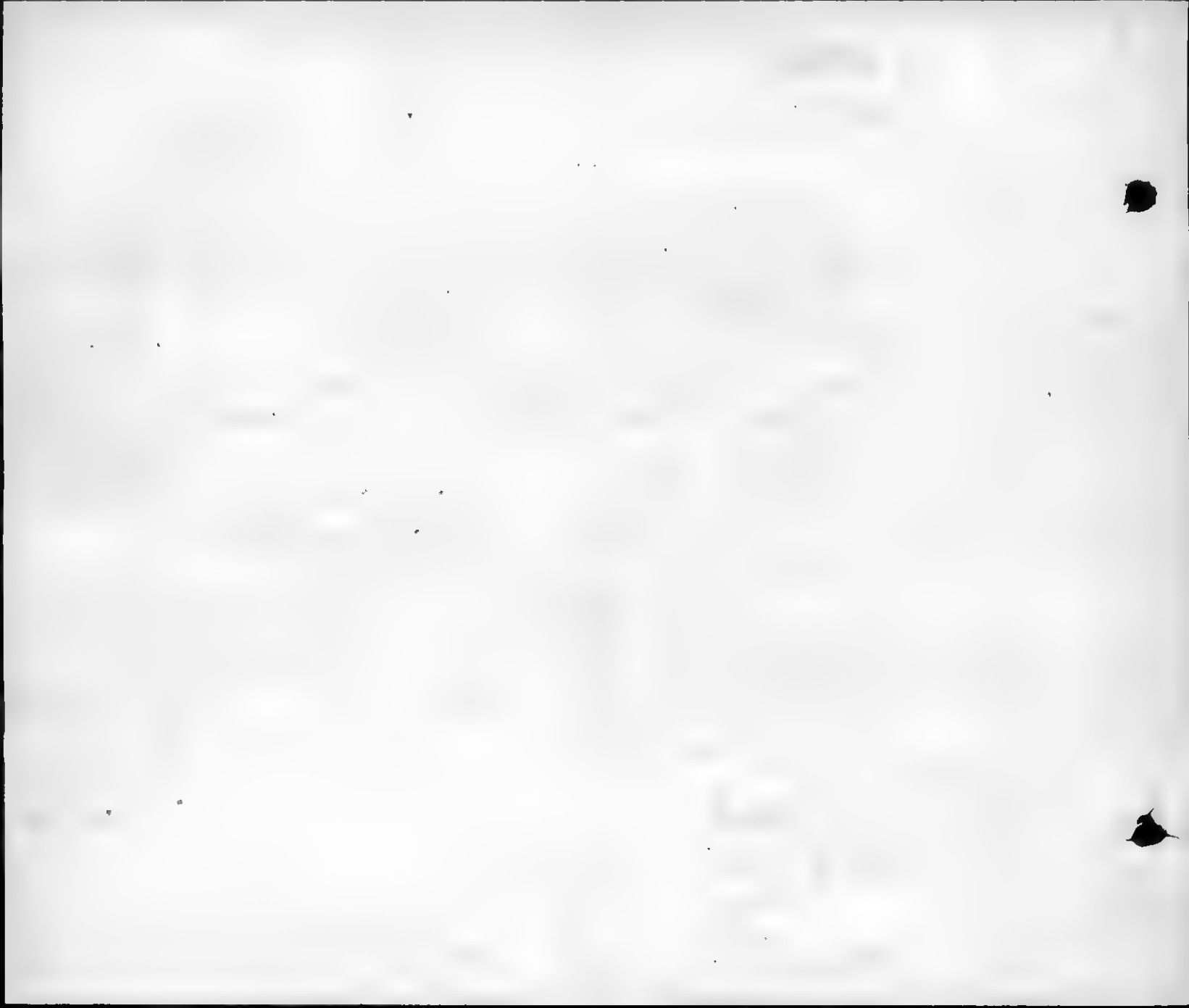
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10761

10748

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 50 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARLOCK MEM. CONV. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle HASTLER Last EYERLY				4. DATE OF DEATH Month SEPTEMBER Day 17 Year 19 60			
5. SEX MALE		6. CO. OR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/1871	
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DANIEL EYERLY				14. MOTHER'S MAIDEN NAME EMILY J. WINDERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT MR. JAMES EYERLY HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420-0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 yrs INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-60 to 8-17-60 , that (I) (we) last saw the deceased alive on 8-16-60 , and that death occurred at 14 M, from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 9/15/60			
22c. PHYSICIAN'S NAME (Type) Dr. E. W. D. T. T. J.				22d. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMAT OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/19/60		23c. NAME OF CEMETERY OR CREMATORY ST PAULS CHURCH CEM.		23d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR SEP 20 '60		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

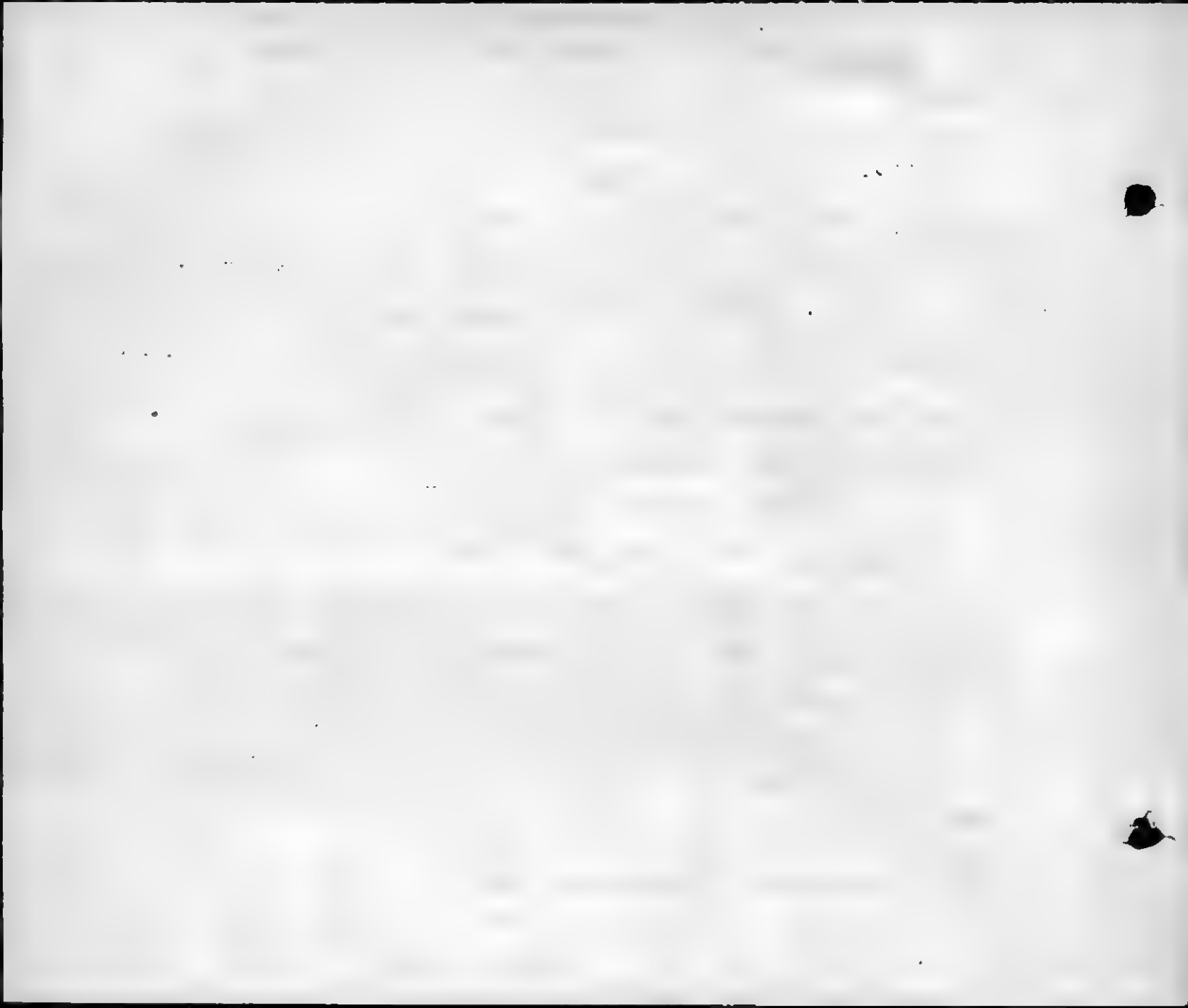
Reg. Dist. No.

10740

10808

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weaverton</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>811 George Street Baltimore Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>811 George Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Donald</u> Middle <u>Fletcher</u> Last				4. DATE OF DEATH <u>September-5th.-</u> 1960 Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-12-1898</u>		9. AGE (in years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer In General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In General</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. Yes</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Susie Fletcher 811 George Street</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>822X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>FRACTURED SKULL, CRUSHED CHEST, CRUSHED LEFT SHOULDER, FRACTURED RIGHT ARM, LEFT CLAVICLE</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Truck overturned</u>					
20c. TIME OF INJURY Month, Day, Year <u>9-5 1960</u> Hour a. m. <u>11:30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT 340 WEAVERTON</u>		20f. (City or town) (County) (State) <u>WEAVERTON WASH CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>DR E W DITTO, JR</u> NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eloy C. Wilson 1000 Brantley Ave</u> ADDRESS				24a. REC'D BY REGISTRAR <u>SEP 8 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 11/59

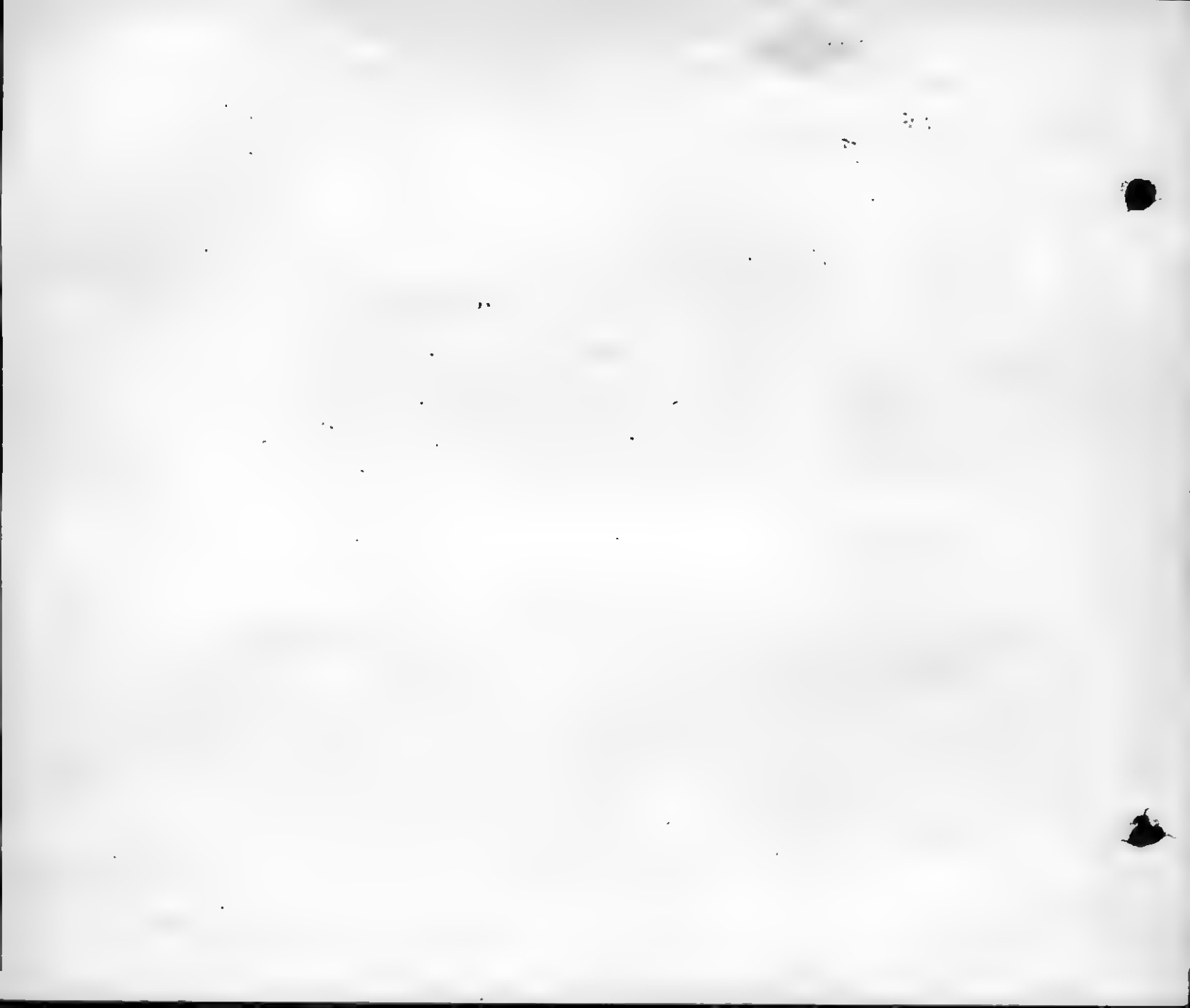
10799

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10750

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 LAKIN AVE (Private Home)</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY BIGGS FRIEND</u>				4. DATE OF DEATH <u>SEPTEMBER-15-1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL-25-1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs		10. MONTHS <u>4</u> DAYS <u>20</u> HOURS <u></u> MIN <u></u>		11. BIRTHPLACE (State or foreign country) <u>ST. JAMES WASH. CO MD U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>			
13. FATHER'S NAME <u>JACOB FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>ALICE HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>HUGH A. FORD</u> Address <u>BOONSBORO MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u>							<u>6 yrs</u>
450.0 DUE TO (b) <u>Acute hemorrhage from peptic ulcer</u>							<u>5 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 7, 1960</u> to <u>Sept. 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 14, 1960</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Lick</u>				22b. DATE SIGNED <u>9/16/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. Lick</u>				22d. ADDRESS <u>Boonsboro Md</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT-18-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SHARPSBURG MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. BAST</u>				25a. REC'D BY REGISTRAR <u>1300NS138RD MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Friend</u>	



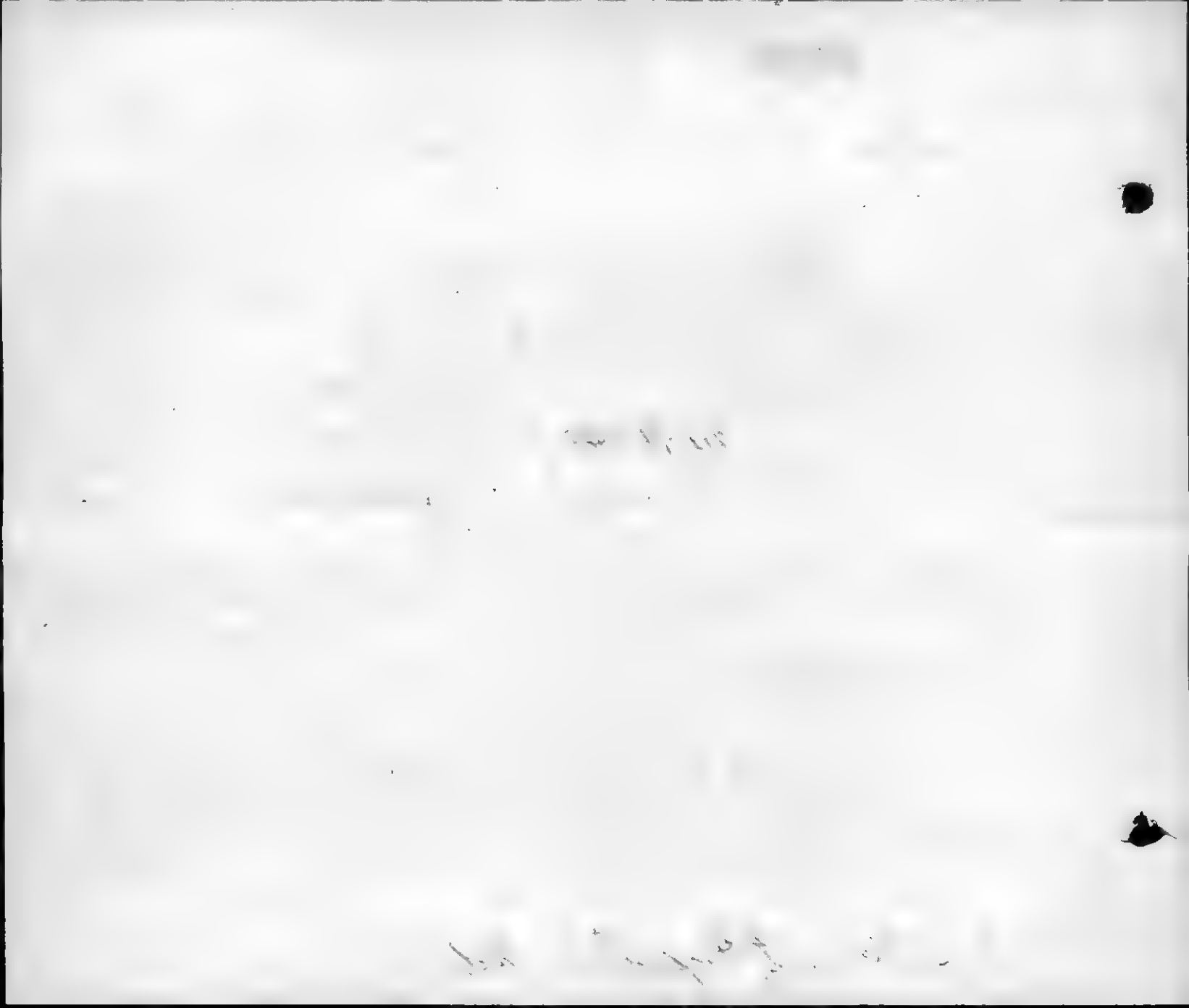


10800

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10751

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO c. LENGTH OF STAY IN 1b 10 MO. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1621 VIRGINIA AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle JEFFERSON Last FUNKHOUSER				4. DATE OF DEATH Month SEPTEMBER Day 27 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/22/1882	
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 7 Days 18 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GUARD				10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME GODFREY FUNKHOUSER				14. MOTHER'S MAIDEN NAME MARY JANE STEELE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 212-14-6488		17. INFORMANT MR. LUTHER FUNKHOUSER		Address CLEARSPRING MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 10, 1960 to Sept 27, 1960 , that (I) (we) last saw the deceased alive on Sept 26, 1960 , and that death occurred at 2 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. W. Wilson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/28/60	
22c. PHYSICIAN'S NAME (Type) G. W. Wilson				22d. ADDRESS Boonsboro Md.			
23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		23b. DATE THEREOF 9/29/60		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horneant				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 30 '60 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

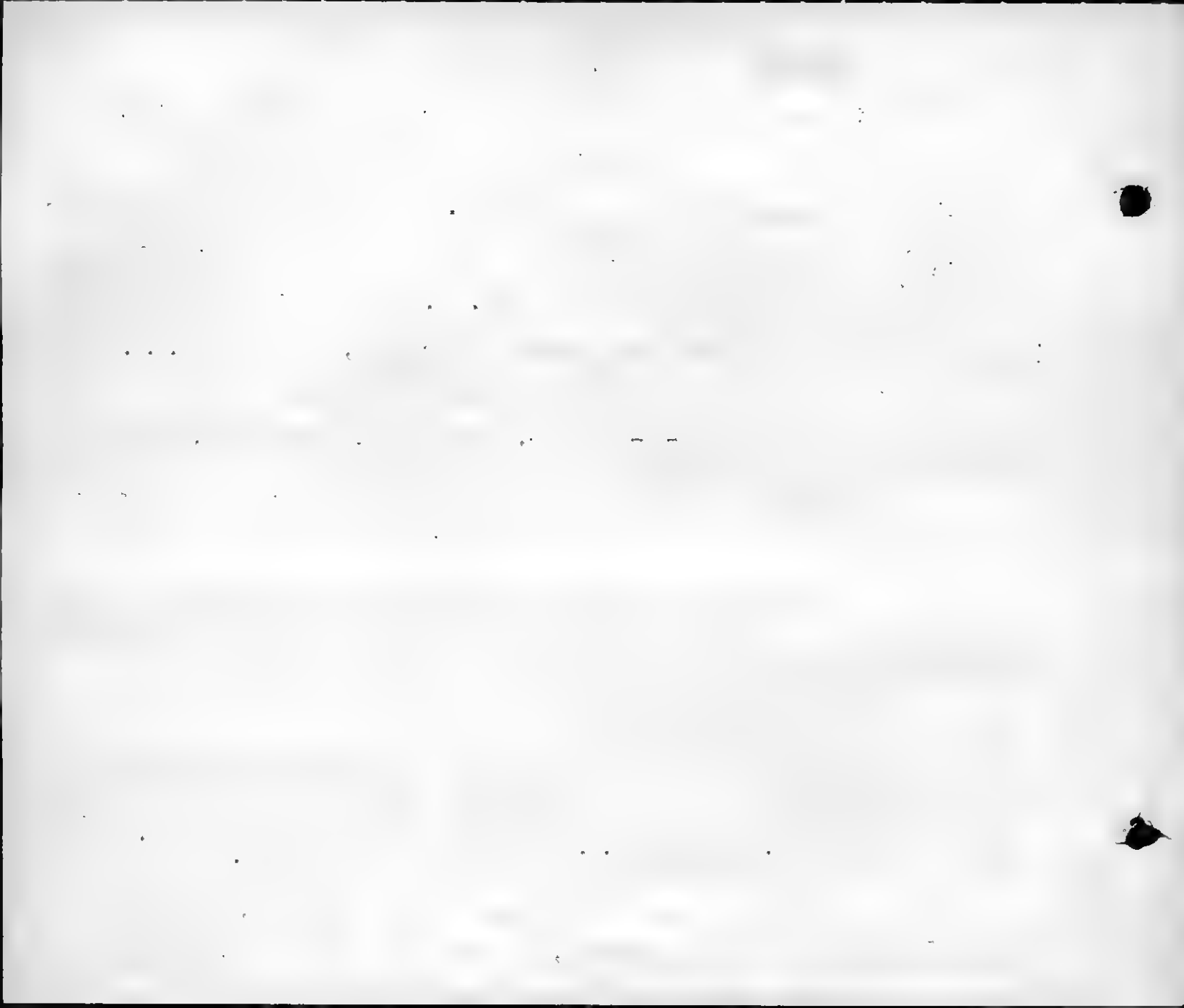


1
10762
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10752

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b most of Life				d. STREET ADDRESS 1423 S. Potomac Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle ERROL Last GEARY				4. DATE OF DEATH Month September Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1899		9. AGE (In years last birthday) 61 yrs	10. UNDER 1 YEAR Months 0 Days 0	11. UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company		11. BIRTHPLACE (State or foreign country) Clearspring, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Geary				14. MOTHER'S MAIDEN NAME Mary Jane Secrist			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-0900715		17. INFORMANT Address Mrs. Lorraine Geary Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis with r. hemiplegia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 days - Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-18, 1939 to 9-19, 1960 ; that (I) (we) last saw the deceased alive on 9-19, 1960 , and that death occurred 9-19, 1960 , from the causes and on the date stated above							
22a. SIGNATURE John H. Hornbaker M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 9-20-60	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 West Washington St., Hagerstown, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Berger				25a. REC'D BY REGISTRAR DATE SEP 23 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION



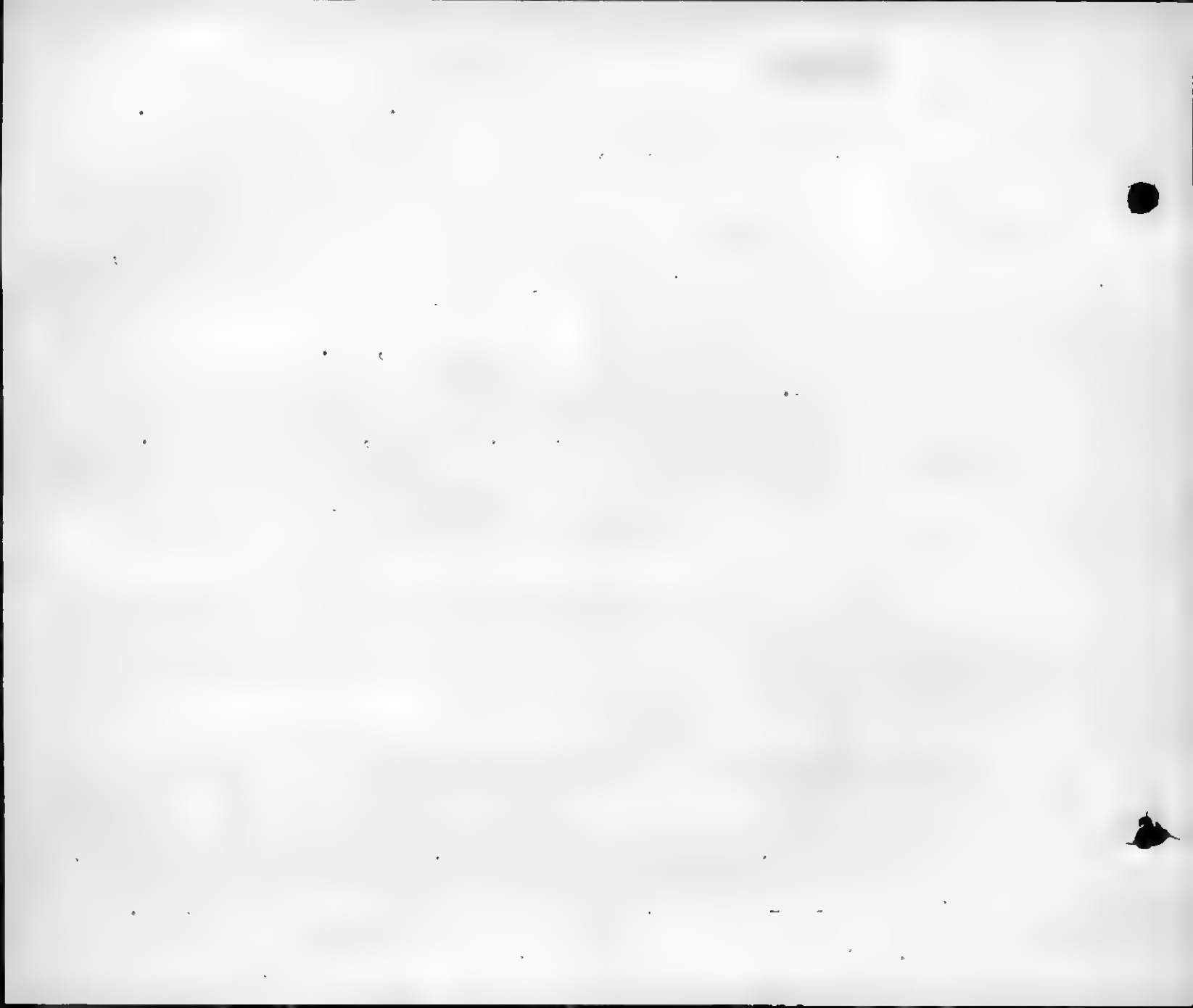
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10753

10809

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown		c. LENGTH OF STAY IN 1b 9 1/2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lessie Middle Leona Last Gerhart		4. DATE OF DEATH Month Sept. Day 9 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1885
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 14 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Big Pool, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David L. Repp		14. MOTHER'S MAIDEN NAME Amanda Shadrach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Gus R. Gerhart, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Calcification 42c DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 30 minutes 147 191			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Sept 9, 1960 that (I) (we) last saw the deceased alive on Sept 6, 1960 , and that death occurred at 11 M, from the causes and on the date stated above			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 9/10/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-60	
23c. NAME OF CEMETERY OR CREMATORY Shanktown Cemetery		23d. LOCATION (City, town, or county) (State) near Big Pool, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 13 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

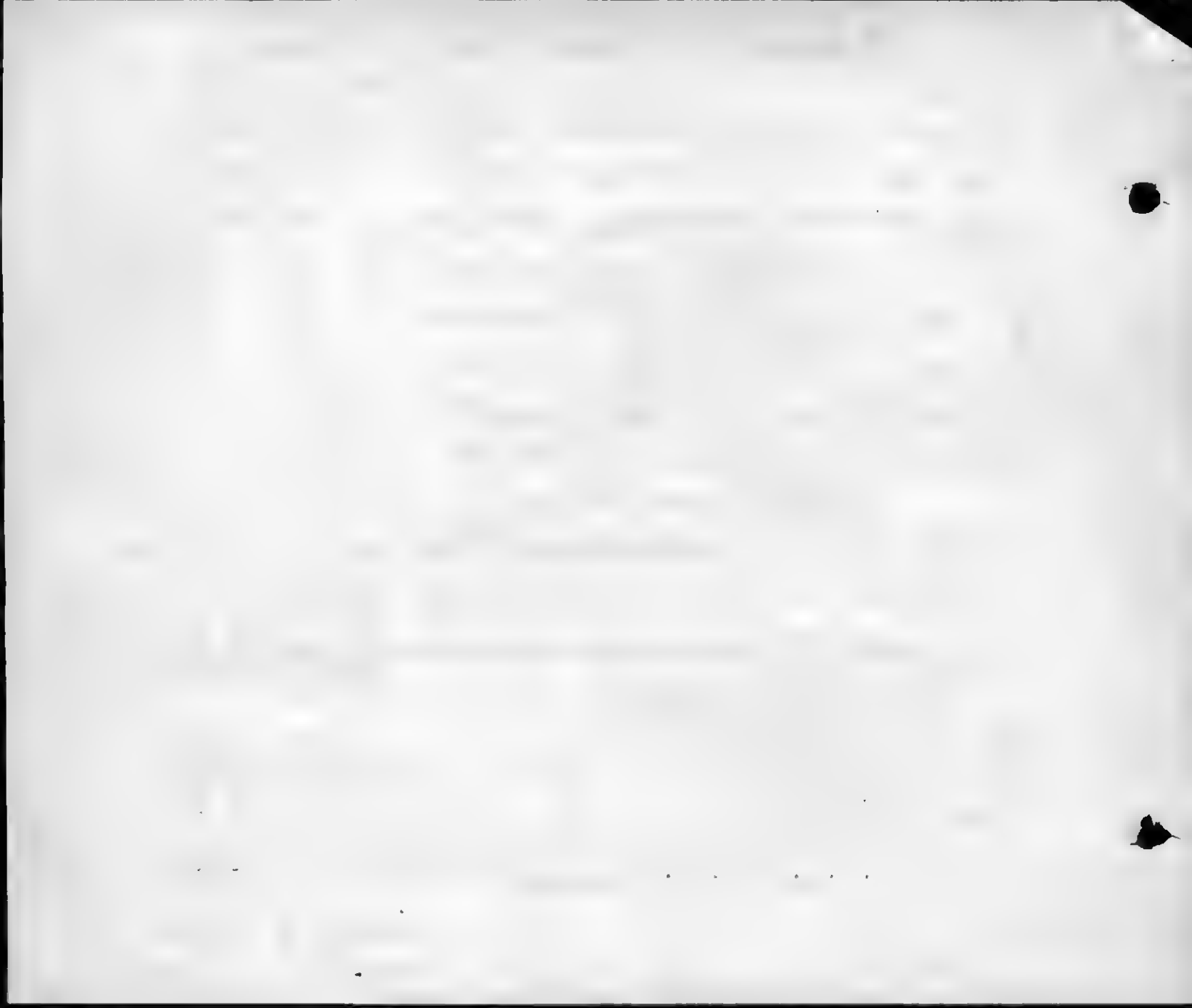
10763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10754

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>LEE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DIXON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>316 GARLINGER AVENUE</u>				d. STREET ADDRESS <u>523 DEPOT STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>LANA</u> Middle <u>GLOVER</u> Last <u></u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 6, 1903</u>		9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MAPLEVILLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD T. STOFFER</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE GALOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>MRS. L. R. BRITCHER</u> Address <u>316 GARLINGER ST. HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>20.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Recent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. E. Ditto</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-22-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 24, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HADEL HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DIXON, ILLINOIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Verast</u>				ADDRESS <u>POONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 3 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Hester</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



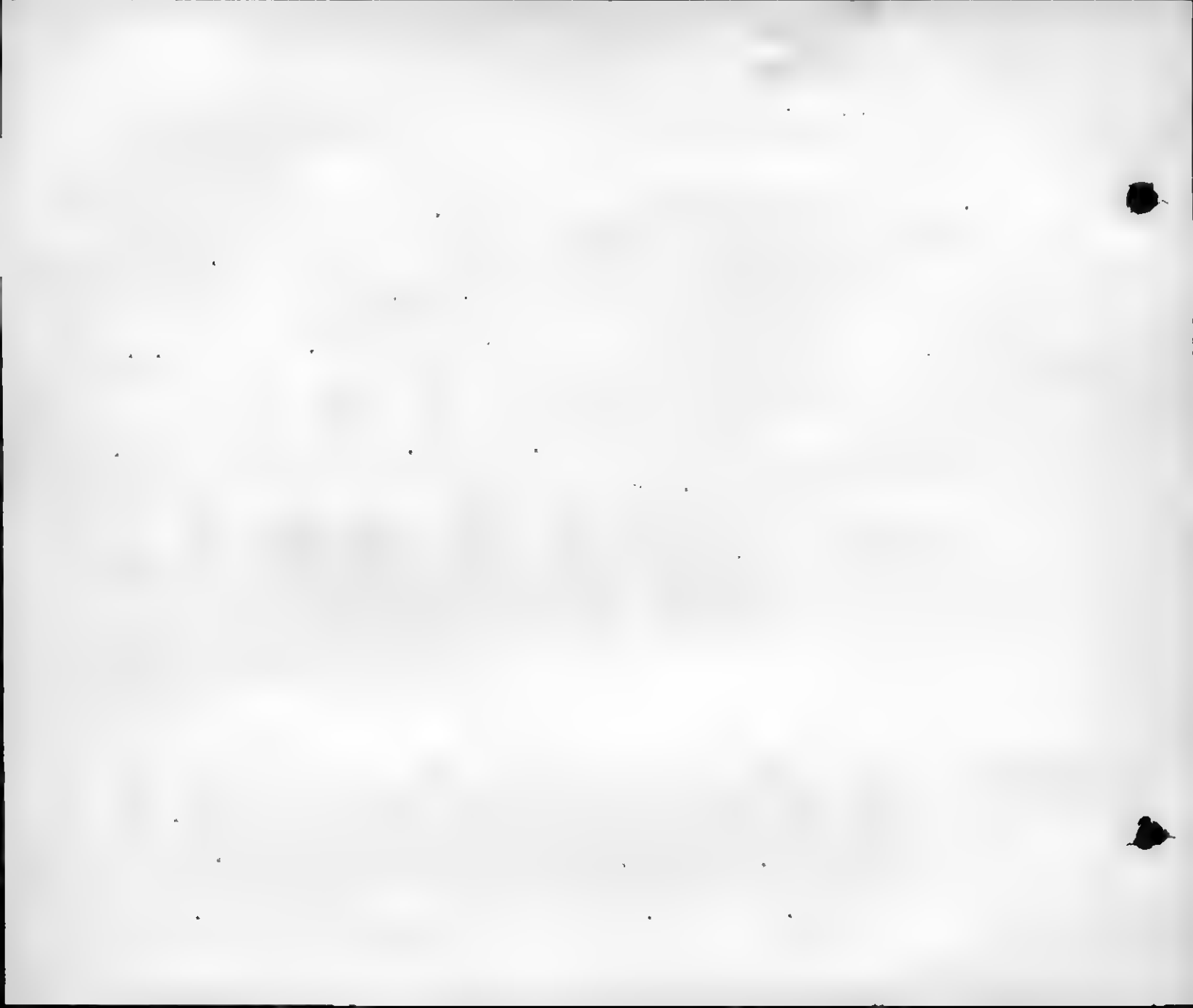
may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10755

10764

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg			
f. STREET ADDRESS 1207 W. Main Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oliver Middle Murphy Last Grove				4. DATE OF DEATH Month Sept. Day 28 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20 1881	
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 5 Days 7		11. IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Sharpsburg Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Otho Grove				14. MOTHER'S MAIDEN NAME Ella Swain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 232-610429		17. INFORMANT Mr. Clyde W. Grove Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of left leg DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Embolus of Left common iliac artery and (c) Multiple emboli to brain and lungs (d) Arteriosclerotic heart disease with auricular fibrillation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 Yrs INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days 3 days 5 Yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Walter H. Shealy attended the deceased from 9/20/60 19 to 9/28/60 19, that (I) (we) last saw the deceased alive on 9/27/60 19, and that death occurred at 8A M. from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Shealy				22b. DATE Sep. 29, 1960		22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 30-60		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
23d. LOCATION (City, town, or county) Sharpsburg Md.				23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Abner Britton, Baltimore, Md.				25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	



13
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10810

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

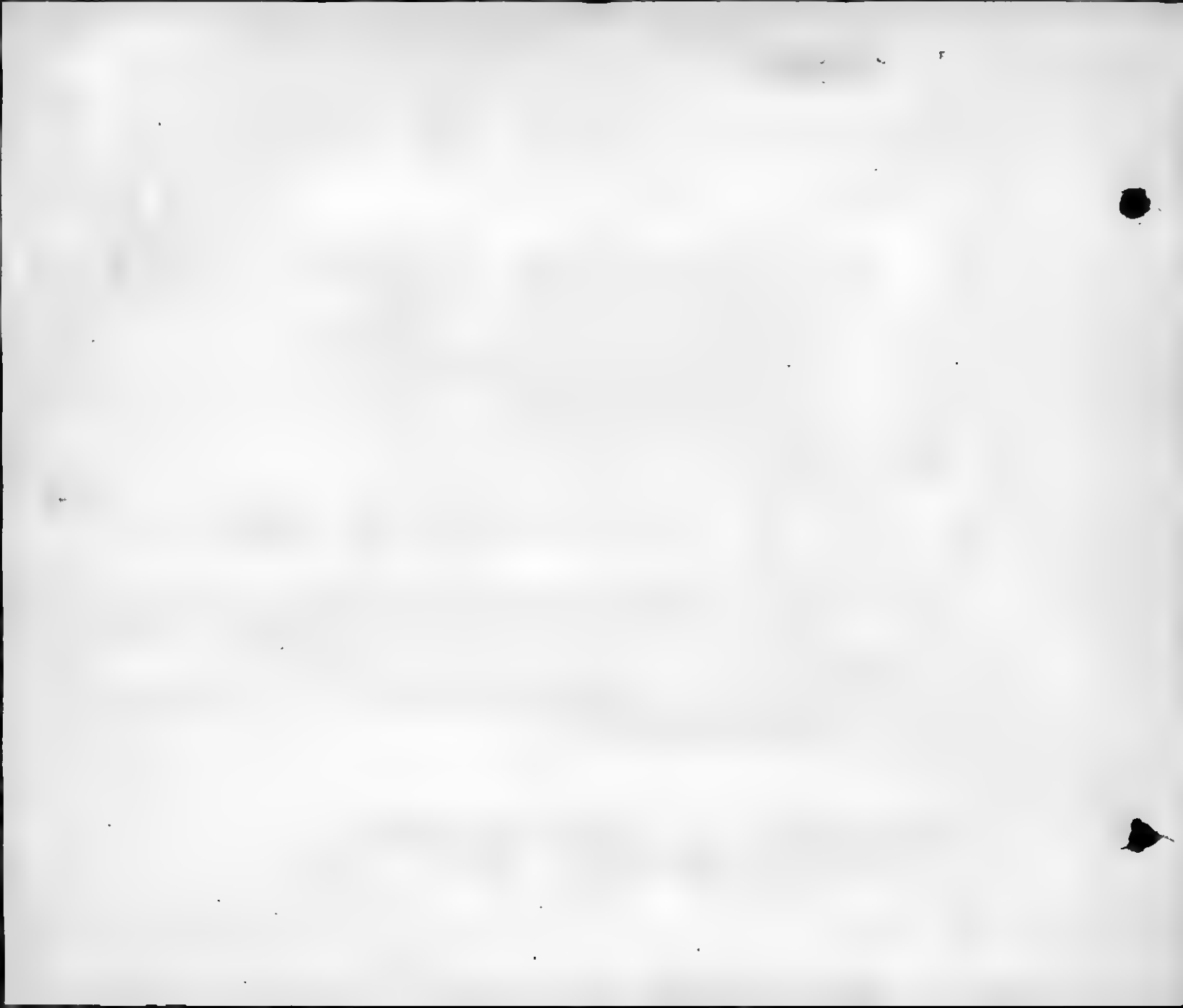
10756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>		c. LENGTH OF STAY IN 1b <u>9 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KEEDYSVILLE MD.</u>				d. STREET ADDRESS <u>KEEDYSVILLE MD.</u>			
3. NAME OF DECEASED (Type or print) <u>FRANK ALLEN HAMMOND</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 30 1884 - 75 yrs.</u>	
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>SHARPSBURG WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NO RECORD</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HAMMOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 36-6544</u>		17. INFORMANT <u>ROYA HAMMOND</u> Address <u>KEEDYSVILLE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> causing the underlying cause last. (c) <u>74 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Died in sleep on bed & the ground (7/10)</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOE W. H. T. 2</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/16/60</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 18 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10757

10811

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>				c. LENGTH OF STAY IN 1b <u>20 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYSVILLE MD.</u>				d. STREET ADDRESS <u>1 KEEDYSVILLE MD</u>			
3. NAME OF DECEASED (Type or print) <u>ROY ALLEN HAMMOND</u>				4. DATE OF DEATH <u>SEPTEMBER 25 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OF RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1908</u>	9. AGE (In years last birthday) <u>52 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARAGE OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN GARAGE</u>		11. BIRTHPLACE (State or foreign country) <u>BAKERSVILLE WASH. Co. MD. U.S.A.</u>	
13. FATHER'S NAME <u>FRANK A. HAMMOND</u>				14. MOTHER'S MAIDEN NAME <u>VERVIE COCHRANE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-05-6696</u>		17. INFORMANT <u>MRS. LELA HAMMOND KEEDYSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15</u> 19 <u>60</u> to <u>Sept 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept 25</u> 19 <u>60</u> , and that death occurred at <u>5 A</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Helan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <u>9/27/60</u> SIGNED <u>med</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Helan</u>				22d. ADDRESS <u>Bonnsboro</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT-27-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BONNSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BONNSBORO WASH. Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				25a. REC'D BY REGISTRAR <u>DATACT 3 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

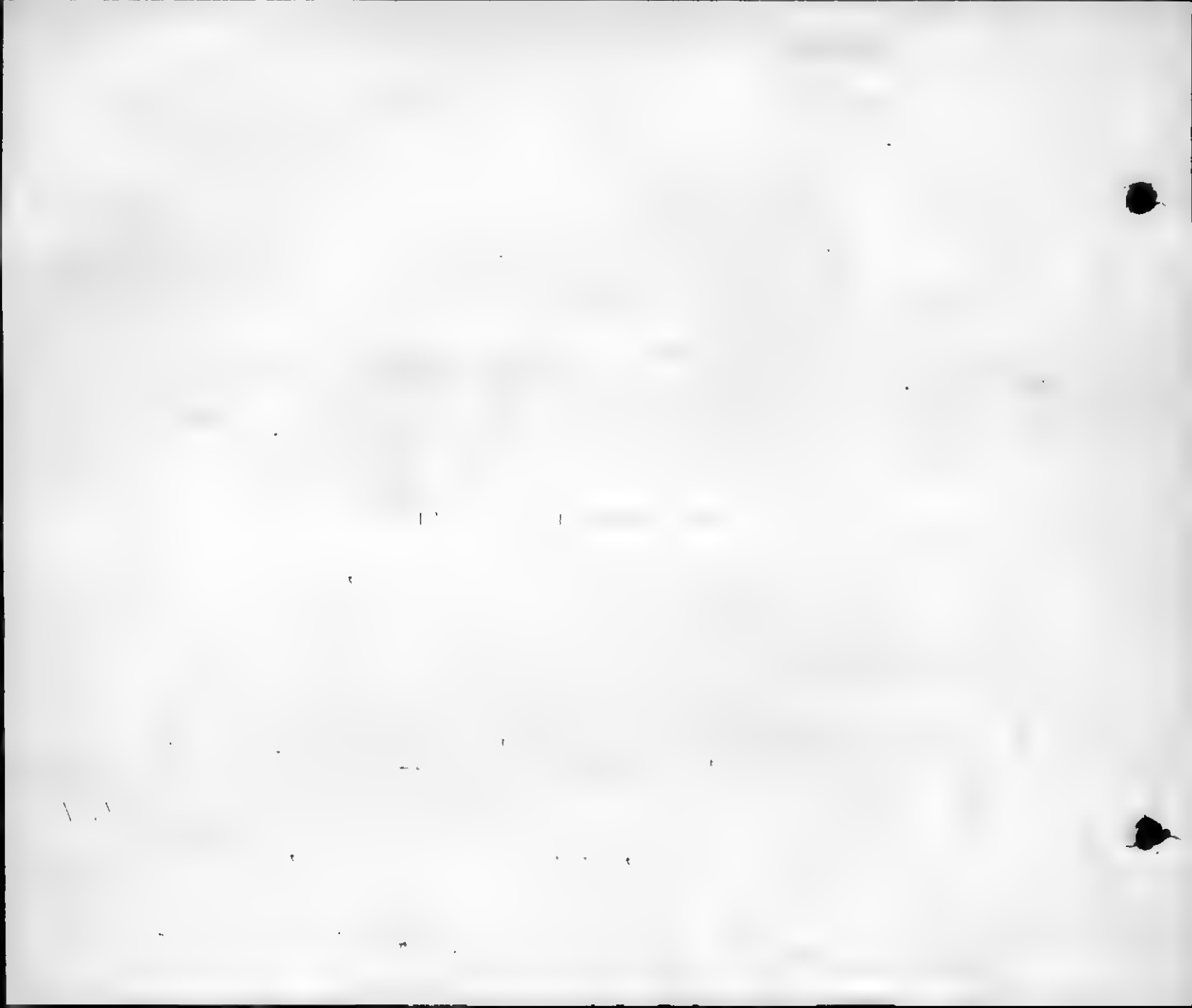


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>10765</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div>10758</div> </div>											
1. PLACE OF DEATH a. COUNTY WASHINGTON				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON							
b. CITY OR TOWN (If outside corporate limits, write HAGERSTOWN)				c. LENGTH OF STAY IN 1b 35 YRS.				c. CITY OR TOWN (If outside corporate limits, write HAGERSTOWN)			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1232 E. FRANKLIN ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GAIL First MARIE Middle HAYS Last				4. DATE OF DEATH SEPTEMBER 16 1960 Month Day Year							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/6/1898		9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. M. YEATES				14. MOTHER'S MAIDEN NAME ELIZA JANE CLOPPER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO 220-10-3385		17. INFORMANT MR. ORVILLE C. HAYS Address 418 SPT.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADRENAL GLAND DEGENERATION DUE TO CARCINOMATOSIS GENERALIZED Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO (b) ADENOCARCINOMA OF THE BREAST, RIGHT DUE TO (c) ADENOCARCINOMA OF THE BREAST, RIGHT										INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN 5 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from APRIL 30 1956 to SEPT. 16 1960 , that (I) (we) last saw the deceased alive on SEPT 15 1960 , and that death occurred at 10:25 AM M, from the causes and on the date stated above											
22a. SIGNATURE <i>Archie Robert Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE 09/18/60 SIGNED			
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.				22d. ADDRESS CLEAR SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/18/60		23c. NAME OF CEMETERY OR CREMATORY SHANKS CHURCH OF BRETHREN				23d. LOCATION (City, town, or county) (State) FRANKLIN CO. PENNA.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Horne</i>				ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR SEP 20 '60 DATE		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Horne</i>	

(M)

(I)



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

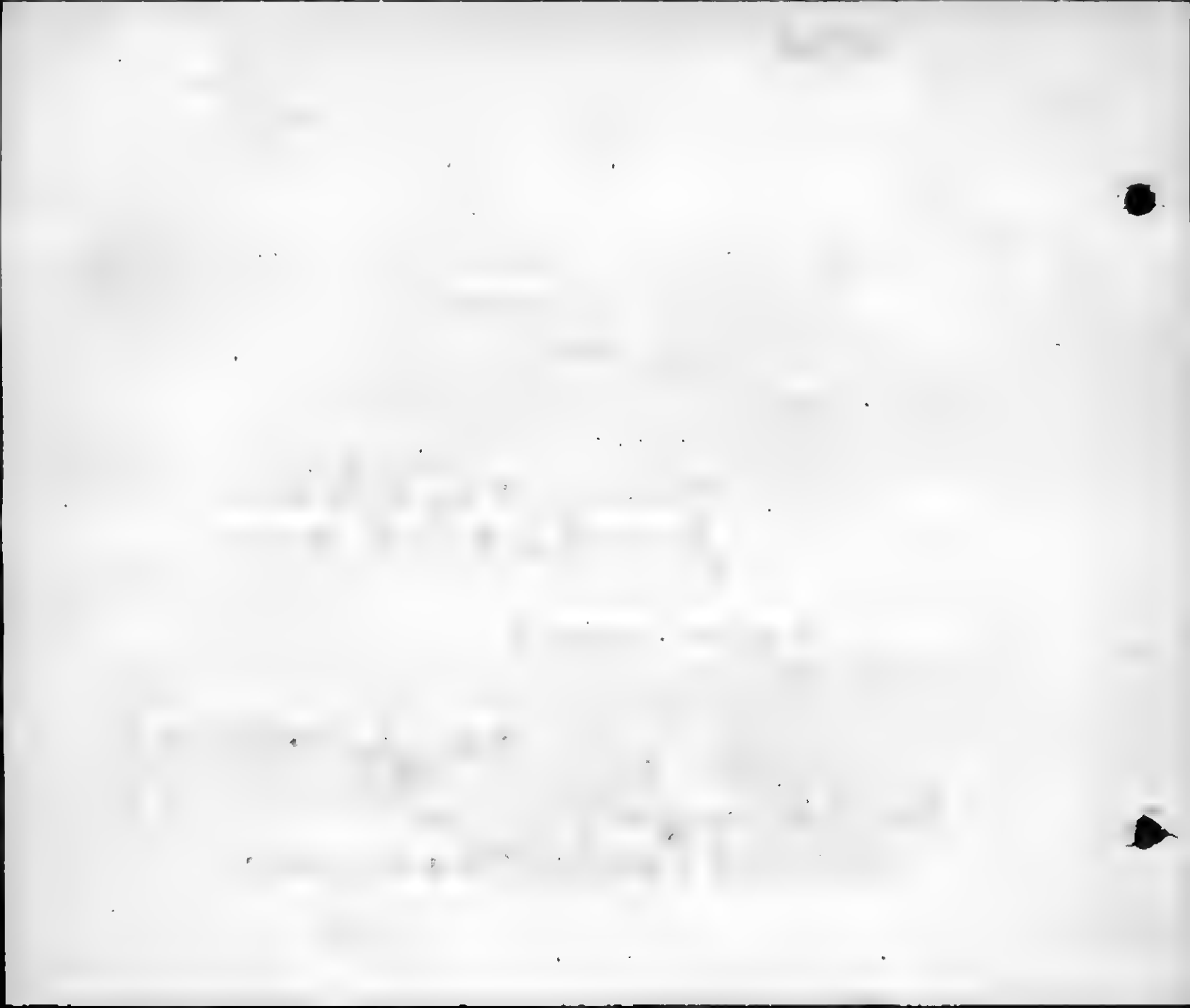
VR A15 (4)
15M 9/59

10766

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

10759

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 Yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 East Howard st				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JACOB BURKETT HOSE				4. DATE OF DEATH Month Day Year September 4 1960 19			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 18 1881		9. AGE (In years lost birthday) 78 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill wright		10b. KIND OF BUSINESS OR INDUSTRY Victor Products		11. BIRTHPLACE (State or foreign country) Willsons Wash Co Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Hose				14. MOTHER'S MAIDEN NAME Sarah Harsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-9141		17. INFORMANT Address Mrs Hilda J. Baker 819 Maryland Ave Hagerstown Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis INTERVAL BETWEEN ONSET AND DEATH 2 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 9/2 19 60 to 9/4 19 60 , that (I) (we) last saw the deceased alive on 9/2 19 60 , and that death occurred at 10:30 M, from the causes and on the date stated above							
22a. SIGNATURE Robert V. L. Campbell M.D.				22b. DATE SIGNED 9/6/60			
22c. PHYSICIAN'S NAME (Type) Robert V. L. Campbell				22d. ADDRESS 145 W Washington ST HAGERSTOWN Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/7/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE SEP 9 '60		25b. REGISTRAR'S SIGNATURE C. L. Thomas	



10761

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10760

1 PLACE OF DEATH a COUNTY <u>WASHINGTON</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c LENGTH OF STAY IN 1b <u>17 DAYS</u> d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>WASHINGTON</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d STREET ADDRESS <u>420 N. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>F</u> Last <u>HUFFER</u>				4 DATE OF DEATH <u>SEPTEMBER - 9 - 1960</u> Month <u>SEP</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1883</u>	9. AGE (In years last birthday) <u>77</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	11. BIRTHPLACE (State or foreign country) <u>MYERSVILLE FREE CO. MD. U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CARLTON P. KAUTZAHN</u>	
14. MOTHER'S MAIDEN NAME <u>CHARLOTTE E. YOUNG</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ELMER C. HUFFER</u> Address <u>420 N. MAIN ST. BOONSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> DUE TO <u>76X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture of hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, pf item 18) <u>Fell on her kitchen floor</u>					
20c. TIME OF INJURY Hour <u>3</u> m. <u>8</u> 22 19 <u>60</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Boonsboro</u>	(County) <u>WASHINGTON</u>	(State) <u>MD</u>		
21 I certify that (I) (this hospital) attended the deceased from <u>8-22-1960</u> to <u>9-9-1960</u> , that (I) (we) last saw the deceased alive on <u>9-4-1960</u> , and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>				22b. DATE SIGNED <u>9/10/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari</u>	
22d. ADDRESS <u>21 North Main St. Boonsboro, Maryland</u>							
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>SEPT. 12, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	23d. LOCATION (City, town, or county) <u>BOONSBORO WASH. CO MD.</u>	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John P. East</u>		ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

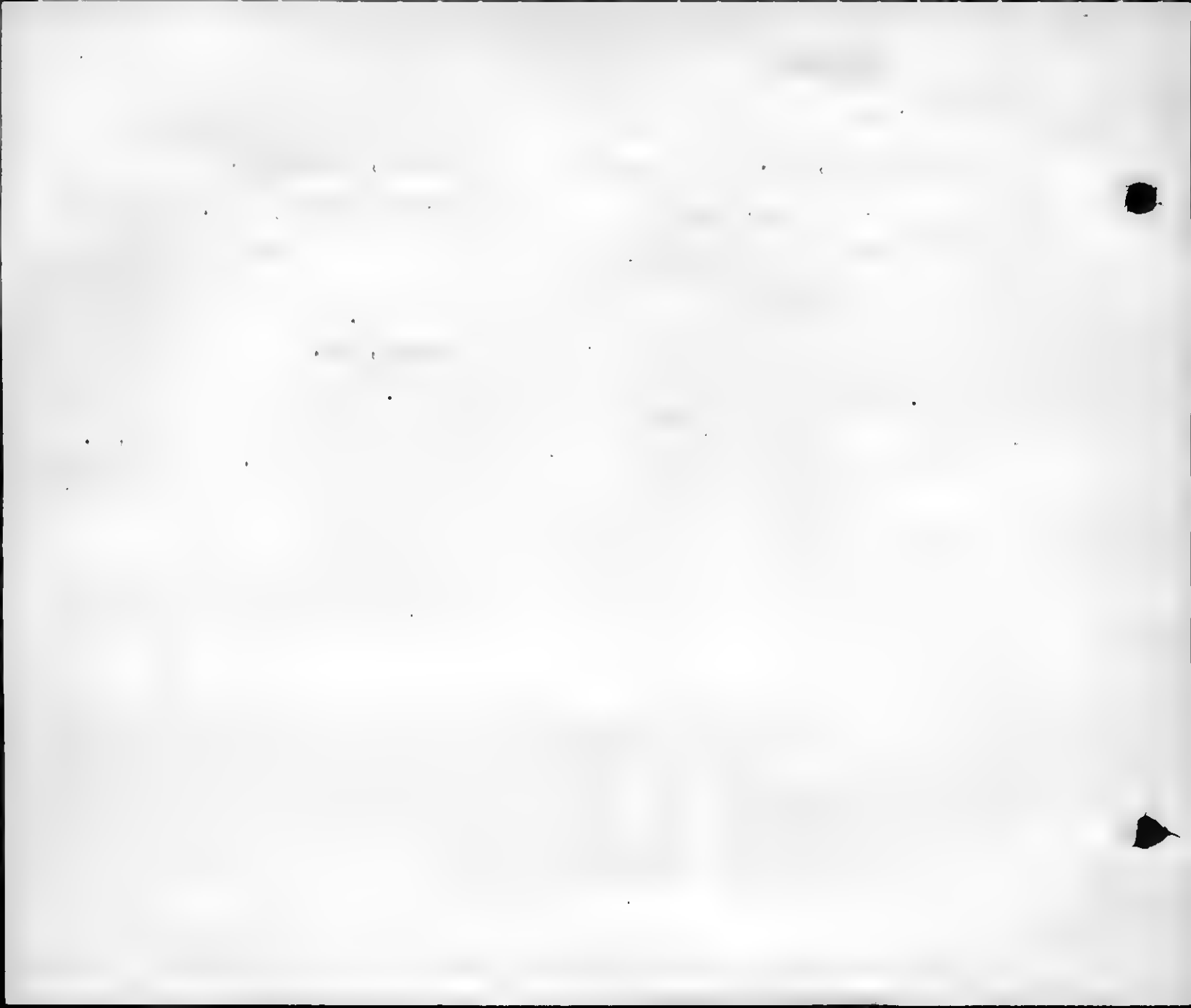
VR A15 (4)
15M 11/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10768

10761

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. 45 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. 63			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 663 Penna Ave Hagerstown, Md				d. STREET ADDRESS 663 Pennsylvania, Ave. 1			
3. NAME OF DECEASED (Type or print) John First Leonard Middle Keats Last				4. DATE OF DEATH Month Sept Day 8 Year 1960			
5 SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 27 1914 46 yrs.	
9 AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft worker		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John H. Keats			
14. MOTHER'S MAIDEN NAME Edmonia R. Lewis				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO 214-09-2109				17. INFORMANT Fannie Keats Address 663 Penna Ave Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C.V. Disease; Rheumatic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 5 min
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21 I certify that (I) (this hospital) attended the deceased from 5/8/60 to 9/8/60 19, that (I) last saw the deceased alive on 8/17 1960, and that death occurred at 9:30 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Campbell M.D.				22b. DATE SIGNED 9/9/60			
22c. PHYSICIAN'S NAME (Type) Robert V. Campbell				22d. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep 13/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md	
24 FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr Hagerstown, Md				25a. REC'D BY REGISTRAR DATE SEP 15 '60		25b. REGISTRAR'S SIGNATURE Charles S. House	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10769

CERTIFICATE OF DEATH

10762

Item 7 Film 0273 10-19-60 et

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Washington Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 633 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Kelsh		4. DATE OF DEATH Month Sept. Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE Color	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1919
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Own Home	
10a. BIRTHPLACE (State or foreign country) Amherst, Virginia		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Huston Slaughter		13. MOTHER'S MAIDEN NAME Florence Grubbs	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		15. SOCIAL SECURITY NO. 215-14-2165	
16. INFORMANT Robert Kelsh		17. Address 633 Pennsylvania Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatous 1/10x DUE TO Carcinoma - breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1949 to Sept. 16, 1960 , that (I) (we) last saw the deceased alive on Sept. 11, 1960 , and that death occurred at 9 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 9/19/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md		25a. REC'D BY REGISTRAR SEP 22 1960	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

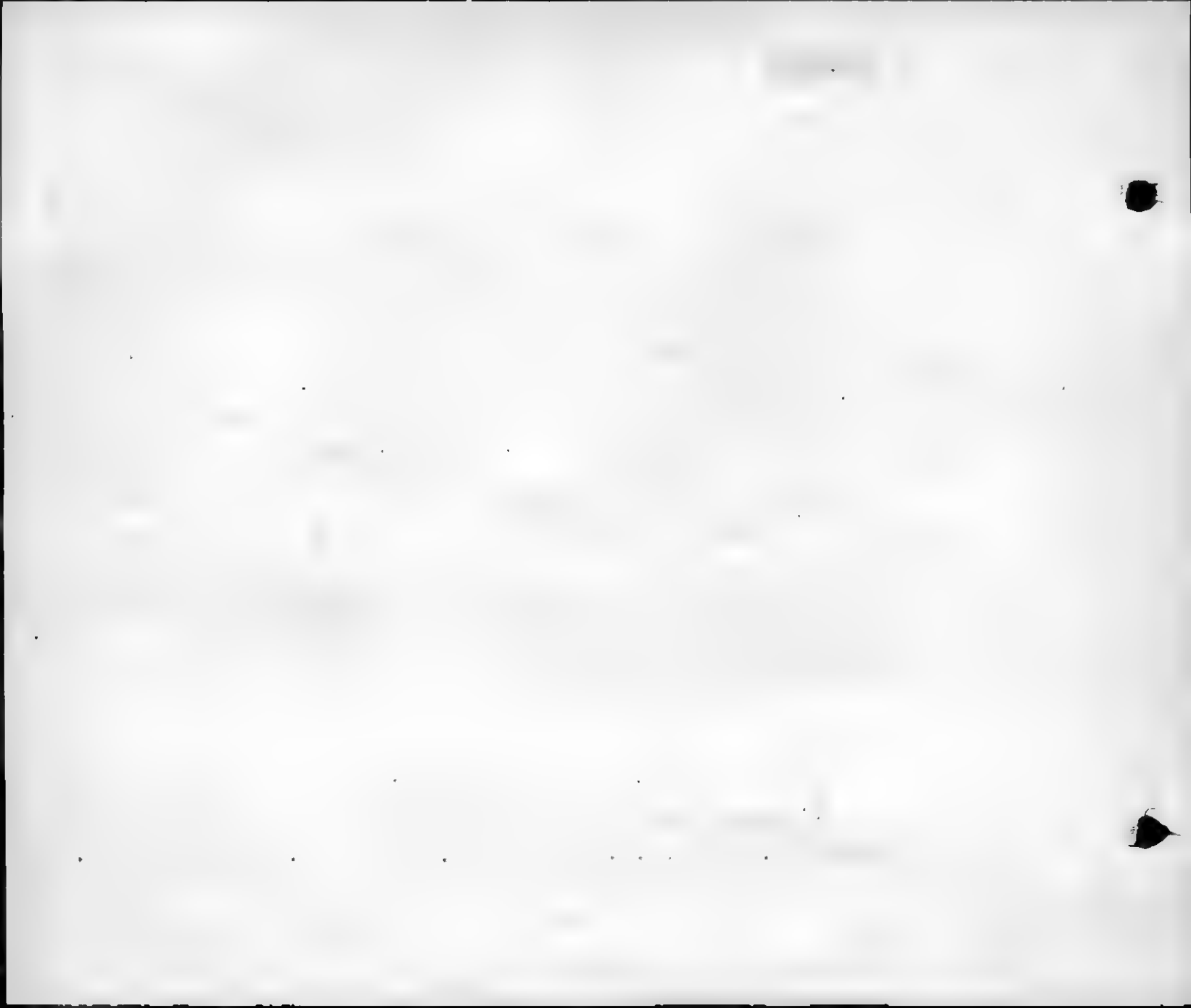
1

10812

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10763

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN				c. LENGTH OF STAY IN 1b 7 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) GATEWAY NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First LOUISE Middle KUHN Last				4. DATE OF DEATH Month SEPTEMBER Day 13 Year 19 60			
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/1/1866	9 AGE (In years lost birthday) 94 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE F. BLOOM				14. MOTHER'S MAIDEN NAME CAROLINE SHUPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT MR. HARRY C. KUHN		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 vascular collapse DUE TO (b) a few sclerotic degenerative arterial disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21 I certify that (I) (this hospital) attended the deceased from 9/13 , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9/13 , 19____, and that death occurred at 4:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 9/14/60				
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.					
23a. BURIAL, CREMATION REMOVED (Specify) BURIAL	23b. DATE THEREOF 9/15/60	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.				
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown Md.		25a. REC'D BY REGISTRAR SEP 15 '60		25b. REGISTRAR'S SIGNATURE William S. Kneass			



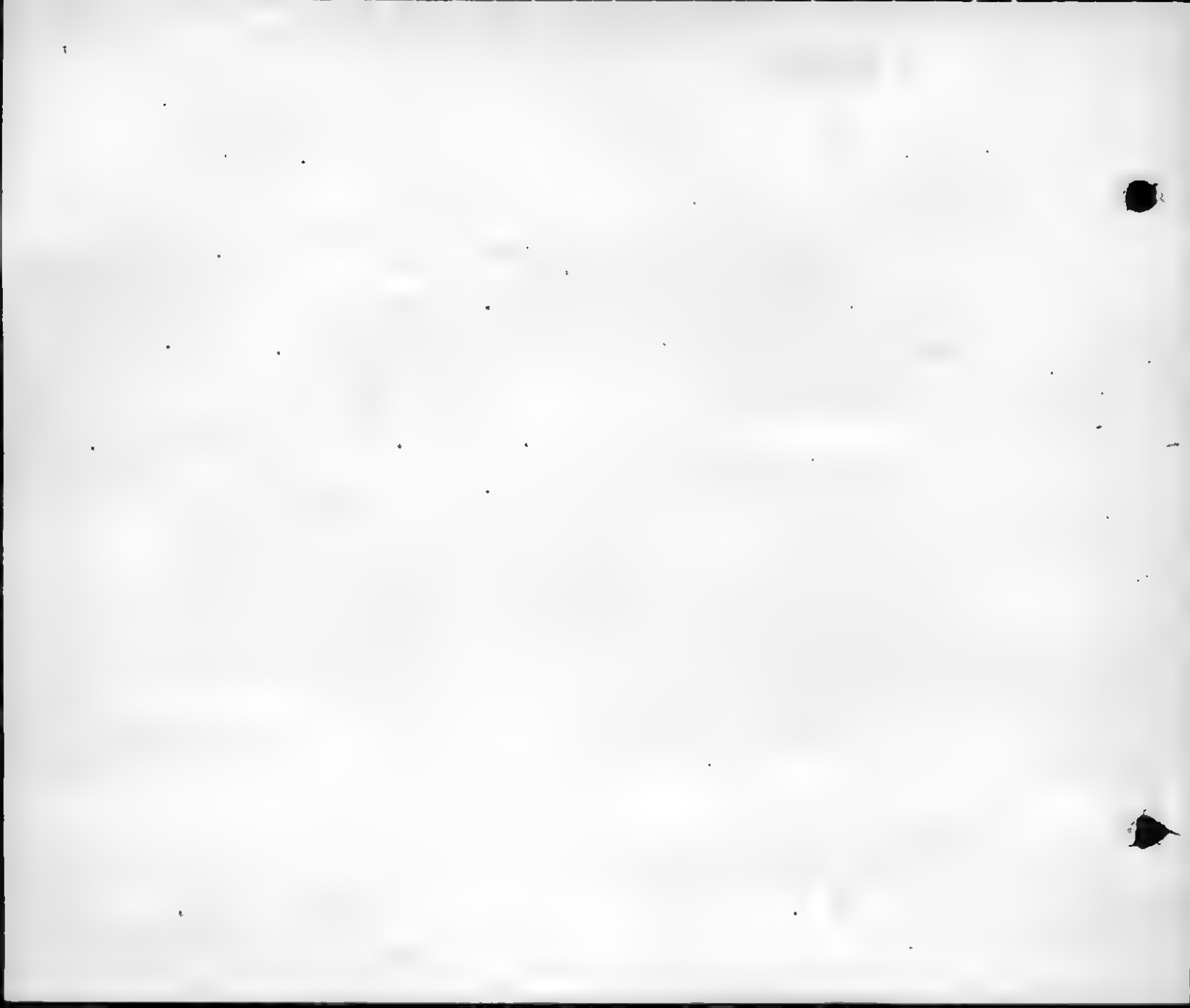
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10770
CERTIFICATE OF DEATH

10764

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS Sharpsburg	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Olan Last Liskey		4. DATE OF DEATH Month Sept. Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20 1888
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 10 Days 0	11. IF UNDER 24 HRS Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Harrisburg Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John Liskey		14. MOTHER'S MAIDEN NAME Katie Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 30 9183	
17. INFORMANT Mr. Allen F. Liskey		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic glomerulo-nephritis			
INTERVAL BETWEEN ONSET AND DEATH 6 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14-1960 to 9-20-1960 that (I) (we) last saw the deceased alive on 9-20-1960 , and that death occurred at 12AM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph Secondary		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARY		22d. ADDRESS BOONSBORO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23-60	
23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		23d. LOCATION (City, town, or county) (State) Bakersville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Williams		25a. REC'D BY REGISTRAR DATE SEP 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Williams			



1

10771

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

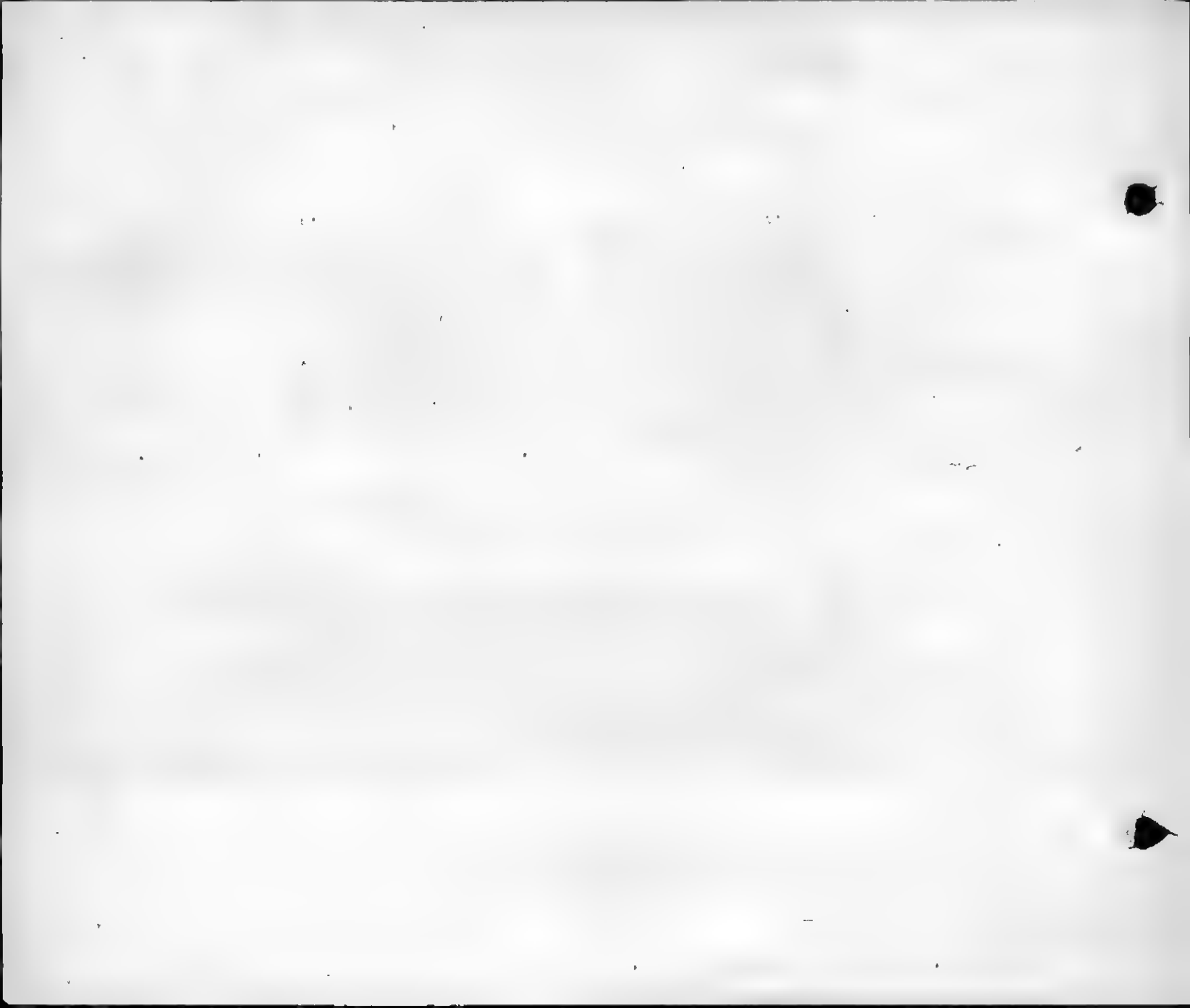
Reg. Dist. No.

10765

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b most of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Norway Ave.,		d. STREET ADDRESS 216 Norway Ave.,	
3. NAME OF DECEASED (Type or print) Clarence Albert Little		4. DATE OF DEATH Month 9 Day 21 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sound Engineer		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Burkittsville, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John William Little		14. MOTHER'S MAIDEN NAME Florence C. Hutts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-32-5567	
17. INFORMANT Mrs. Agnes Little		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 5 min 5 min 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 21, 1960 , to Sept 21, 1960 , that I last saw the deceased alive on Sept 21, 1960 , and that death occurred at 6:30 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Clayd A. Hoffman		ADDRESS (Street, city or town, state) DATE SIGNED 214 N. Potomac St. Hagerstown, Md. 9-22-60	
PHYSICIAN'S NAME (Type) Clayd A. Hoffman		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-24-60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DAT SEP 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

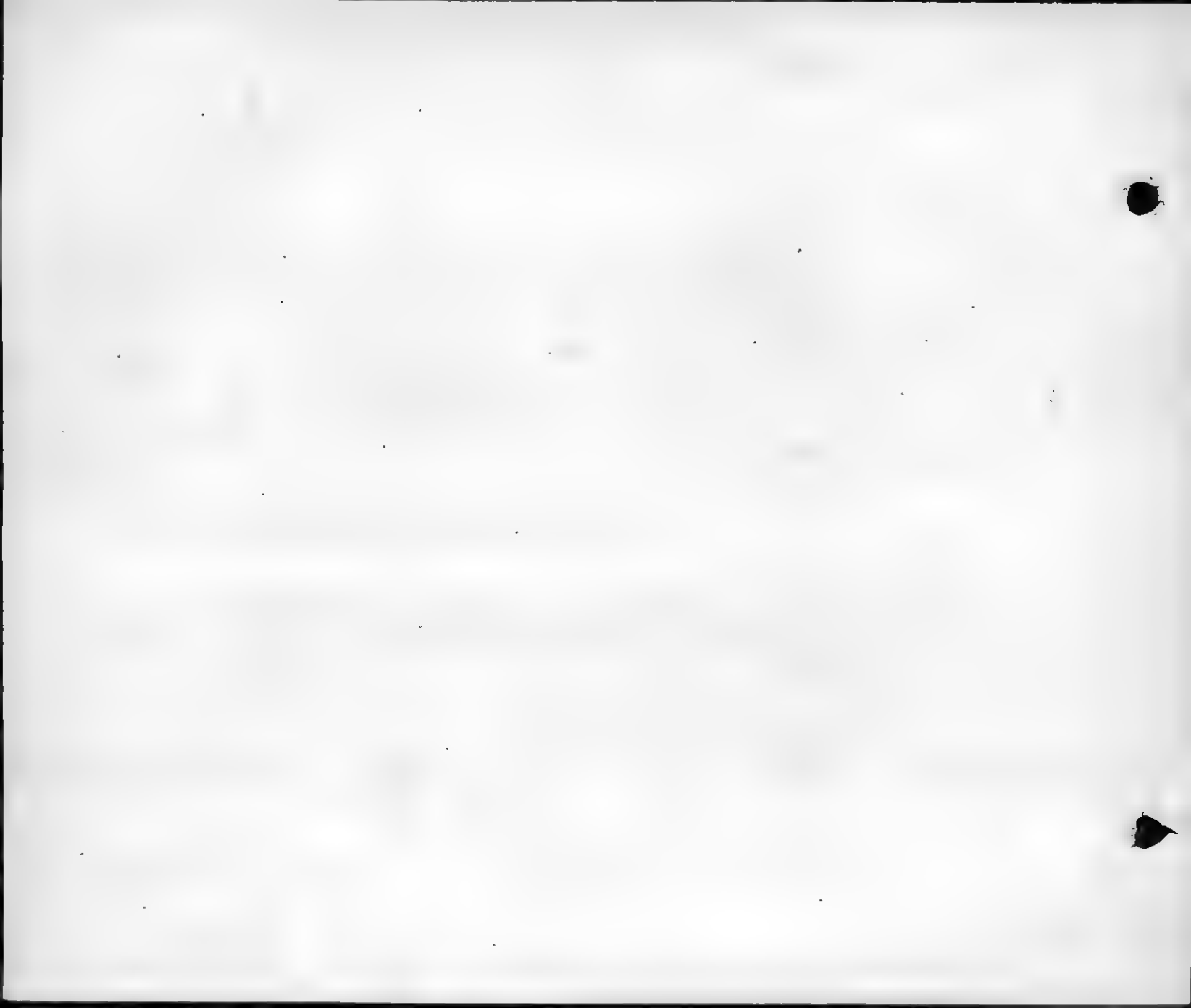


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10772

10766

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 1 WEEK			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WASHINGTON MAY				4. DATE OF DEATH Month Day Year SEPTEMBER 17 1960			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1880	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY HOUSE CONST.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM MAY				14. MOTHER'S MAIDEN NAME LAURA AMBROSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ANNIE V. MAY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Unknown				INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe bronchial asthma & bronchitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug. 14, 1953 to Sept. 17, 1960 that (I) (we) last saw the deceased alive on Sept. 17, 1960 and that death occurred on 9/17/60 , from the causes and on the date stated above.							
22a. SIGNATURE L. L. Parker Jr. M.D.				22b. DATE SIGNED 9/17/60		22c. PHYSICIAN'S NAME (Type) L. L. Parker Jr. MD	
22d. ADDRESS 145 W. Washington St. Hagerstown, Md.							
23a. BURIAL CREMATION, REINTERMENT (Specify) BURIAL		23b. DATE THEREOF 9/20/60		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION (City, town, or county) (State) FREDERICK MD.	
24. FUNERAL DIRECTOR'S SIGNATURE McR. E. Eickman				25a. REC'D BY REGISTRAR SEP 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



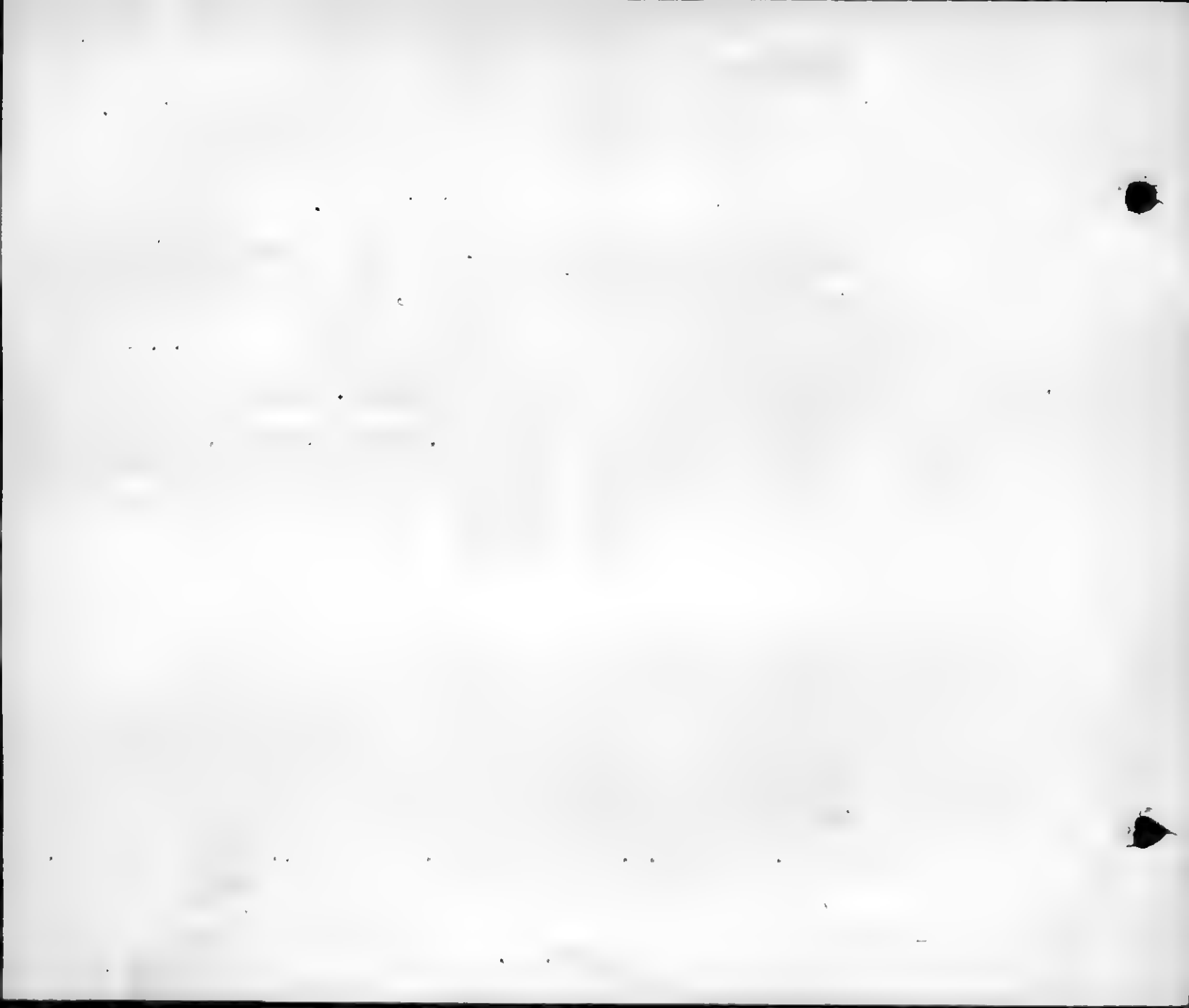
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
107733
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10767

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 825 Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STEPHEN First CRAIG Middle MAYES Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH September 11, 1960 9. AGE (In years last birthday) yrs 2 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		4. DATE OF DEATH September 14 Month 14 Day 19 Year 60 13. FATHER'S NAME Richard Paige Mayes 14. MOTHER'S MAIDEN NAME Esther L. Shaffer 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service.) 16. SOCIAL SECURITY NO none 17. INFORMANT Richard P. Mayes Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X DUE TO Intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 2 days 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 9/11/60 19 to 9/13/60 19, that (I) (we) last saw the deceased alive on 9/13/60 19, and that death occurred at 1 P.M. from the causes and on the date stated above. 22a. SIGNATURE Howard N. Weeks, M.D. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. 22d. ADDRESS 136 N. Potomac St., Hagerstown, Md. 22b. DATE SIGNED 9/16/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/16/1960 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 23d. LOCATION (City or town) (County) (State) Hagerstown, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE R. Frank - Rouzer ADDRESS Hagerstown, Md. 25a. REC'D BY REGISTRAR SEP 20 '60 25b. REGISTRAR'S SIGNATURE	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10774

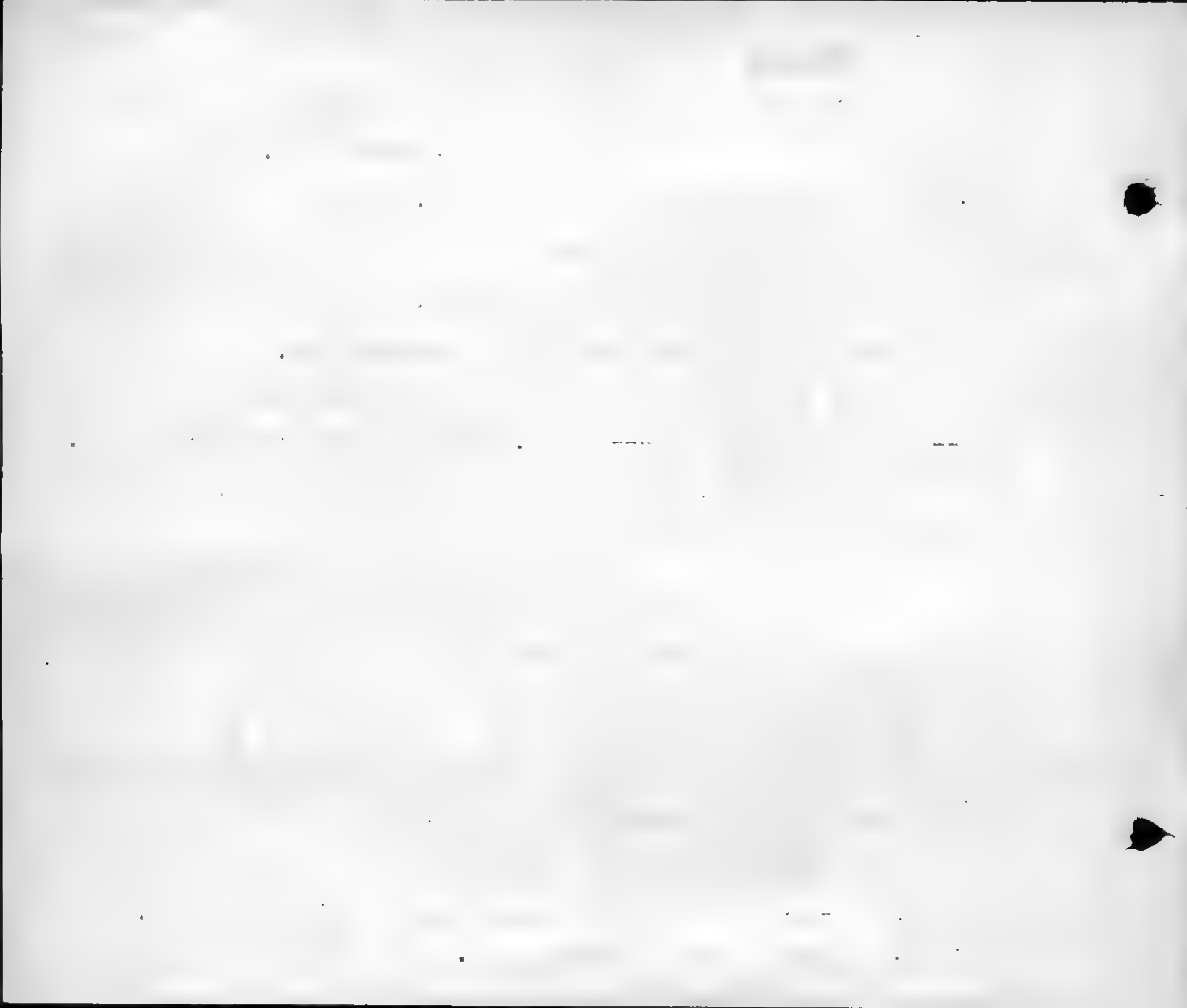
10768

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. d. STREET ADDRESS 522 N. Mulberry e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wyoma Geneva Mentzer First Middle Last		4. DATE OF DEATH September 10 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1874 9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew Semler		14. MOTHER'S MAIDEN NAME Catherine Cramer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Kathryn Shifler		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 4, 1960 to SEPT 10, 1960 , that (I) (we) last saw the deceased alive on SEPT 10, 1960 , and that death occurred at --- M, from the causes and on the date stated above.			
22a. SIGNATURE Scott F. Minnich & Son M.D.		22b. DATE SIGNED SEP 14 1960	
22c. PHYSICIAN'S NAME (Type) SCOTT F. MINNICH & SON		22d. ADDRESS 214 N. Potomac St. Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-13-60	23c. NAME OF CEMETERY OR CREMATORY Leitersburg Luthern	23d. LOCATION (City, town, or county) (State) Leitersburg Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR SEP 14 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Charles L. Hume	

M

I

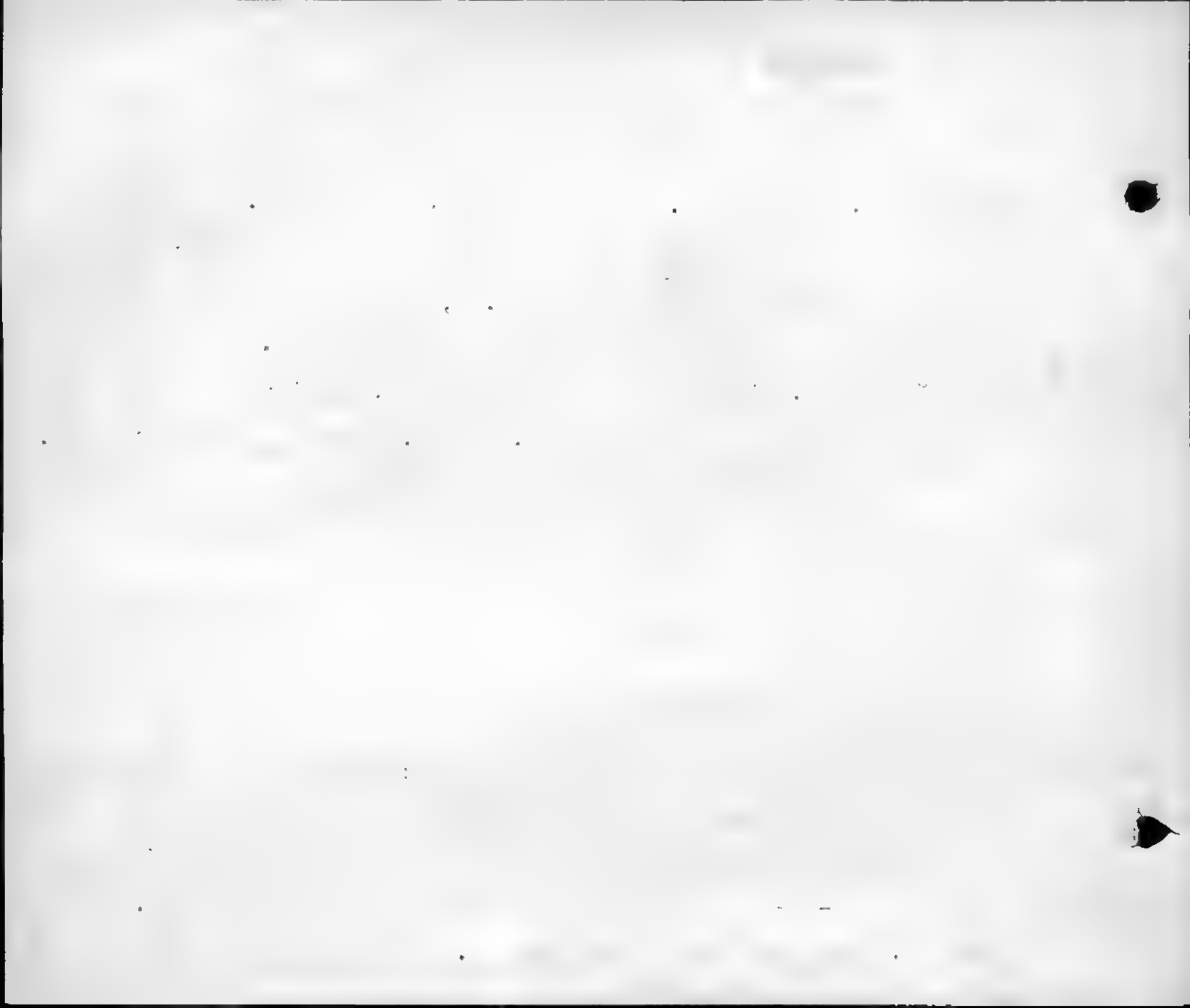


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10769

10775

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 420 W. Franklin St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Charles Miller				4. DATE OF DEATH Month Day Year September 16 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1891	
9. AGE (In years last birthday) yrs. 68		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		10b. KIND OF BUSINESS OR INDUSTRY Metal Stairways		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Charles A. Miller			
14. MOTHER'S MAIDEN NAME Mary C. Spielman				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT Mrs. Edna P. Miller			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163x Carcinoma Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 6 mo			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from May 1 1960 to 9-16-60 , that (I) (we) last saw the deceased alive on 9-14-60 , and that death occurred at 3:10a M., from the causes and on the date stated above.			
22a. SIGNATURE J. E. W. Dittor				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) J. E. W. DITTOR				22d. ADDRESS Hagerstown Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR DATE SEP 19 '60			
25b. REGISTRAR'S SIGNATURE William S. Hume							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10770

10776

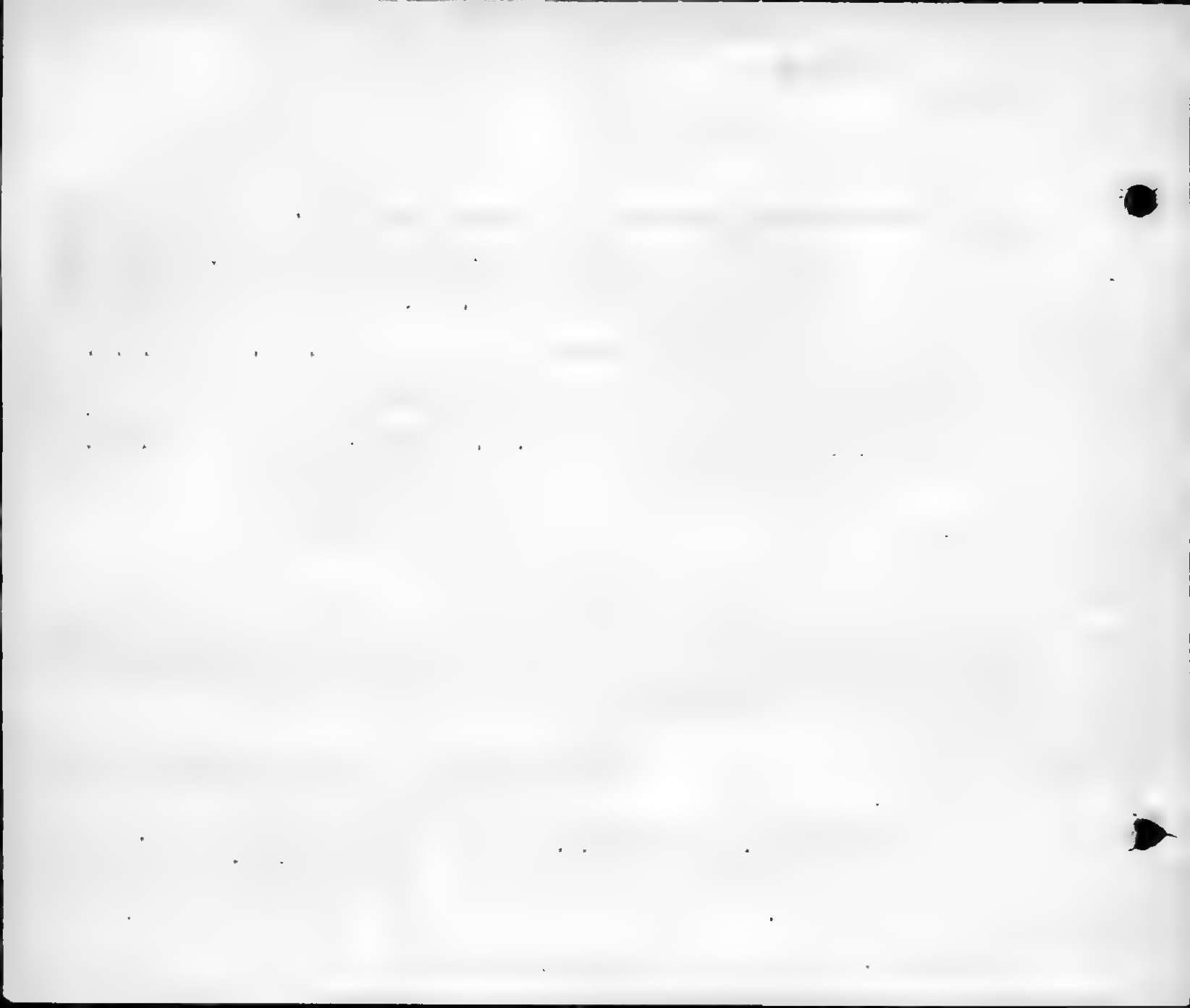
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDNA MAE NICELY			4. DATE OF DEATH Month Day Year Sept. 8 1960				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby. 27, 1886		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 6 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Berkley Co W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Scott Emerson				14. MOTHER'S MAIDEN NAME Rose Tabler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. A. Elizabeth Barton		Address 38 Moller Apt. Hag. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute left ventricular failure (post-operative) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 12 hours the known
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown, Md.		20g. (County) Washington		20h. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 4-20, 1943 to 9-8, 1960 that (I) (we) last saw the deceased alive on 9-9, 1960 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker M.D.				22b. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22c. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 11, 60		23c. NAME OF CEMETERY OR CREMATORY River View Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Wash. Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Md.		25a. RECEIVED BY REGISTRAR SEP 13 60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank							

(M)

091

(I)

MEDICAL CERTIFICATION



VR A15 (4)
15M 9/59

10777

10771

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE PA b. COUNTY FRANKLIN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENCASTLE PA 15	
d. STREET ADDRESS 327 East Belle St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET R NICODEMUS		4. DATE OF DEATH Month Sept Day 20 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24 1897
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 3 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) ANTRIM TWP PA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME W. S. Rahauer		14. MOTHER'S MAIDEN NAME Susan Wetzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 184-65-7463	
17. INFORMANT Ralph M. Nicodemus		Address 327 E Belle Greencastle PA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO (b) Probable phlebotrombosis of leg veins DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH About 45 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked coronary arteriosclerosis. Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above			
22a. SIGNATURE John H. Hornbaker M.D.		22b. DATE SIGNED 9:21:60	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF Sept 23/60	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town, or county) (State) Wagonsburg PA	
24. FUNERAL DIRECTOR'S SIGNATURE H. E. Munnich		25a. REC'D BY REGISTRAR DATE SEP 26 '60	
ADDRESS Greencastle PA		25b. REGISTRAR'S SIGNATURE Arthur S. Howe	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

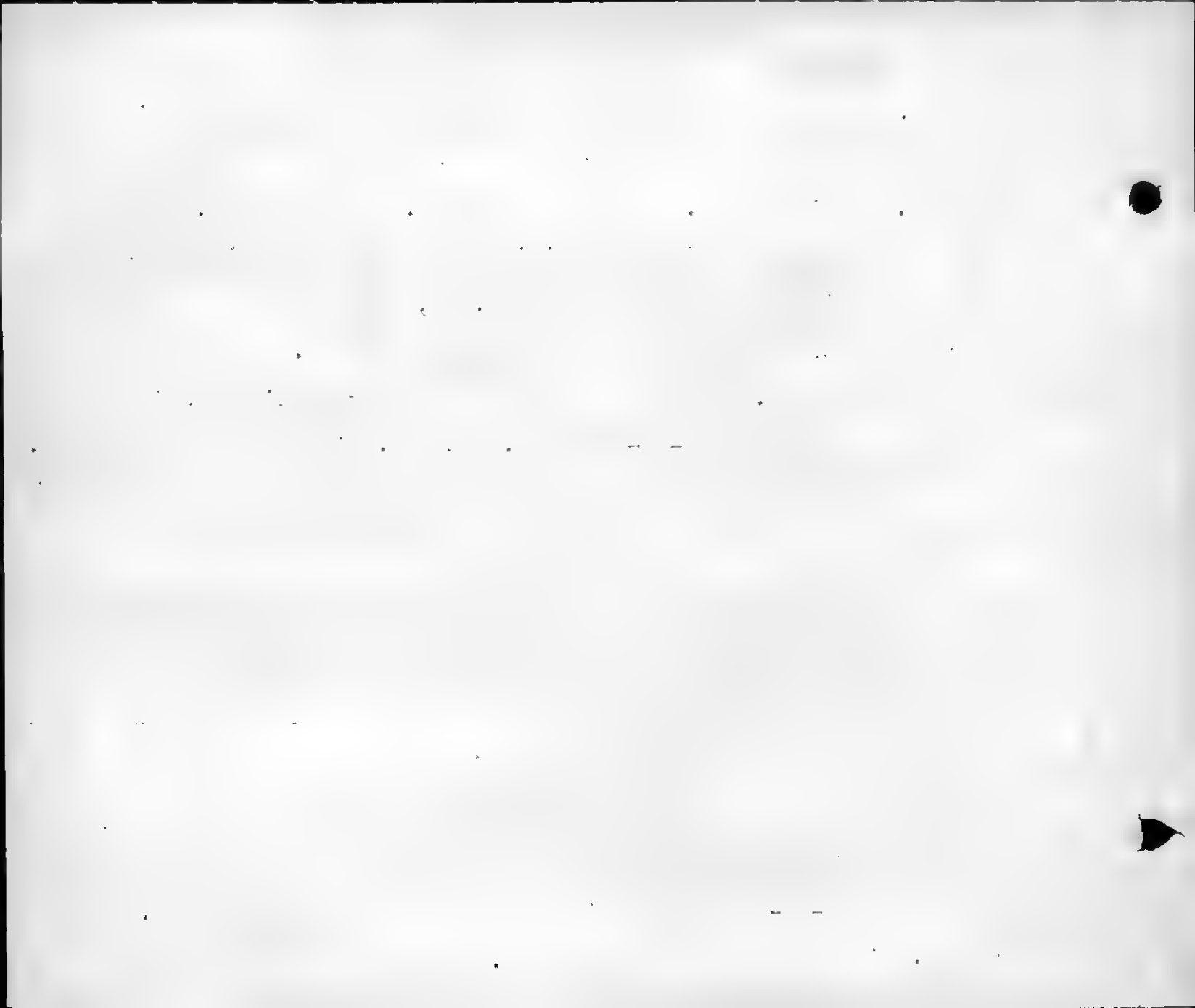
CERTIFICATE OF DEATH

10772

10778

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 56 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 E. Washington St.		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 129 E. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Nikirk		4. DATE OF DEATH Month September Day 17 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1884
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min.	11. IF UNDER 24 HRS. Months 7 Days 17 Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) m Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Boonesboro Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles W. Nikirk		14. MOTHER'S MAIDEN NAME Wilhemina Wallick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-7674	
17. INFORMANT Mrs. Naomi M. Nikirk		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism + F. emb. 27.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 months			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o m. None 19 p m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State) - - -
21 I certify that (I) (this hospital) attended the deceased from Jan. 1960 to Sept. 17, 1960 , that (I) (we) last saw the deceased alive on Sept 16, 1960 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Turco		22b. DATE SIGNED 9-17-60	
22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco		22d. ADDRESS 302 N. Potomac Street-Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-20-60	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.		25a. REC'D BY REGISTRAR SEP 22 '60	
		25b. REGISTRAR'S SIGNATURE Arthur L. Finner	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



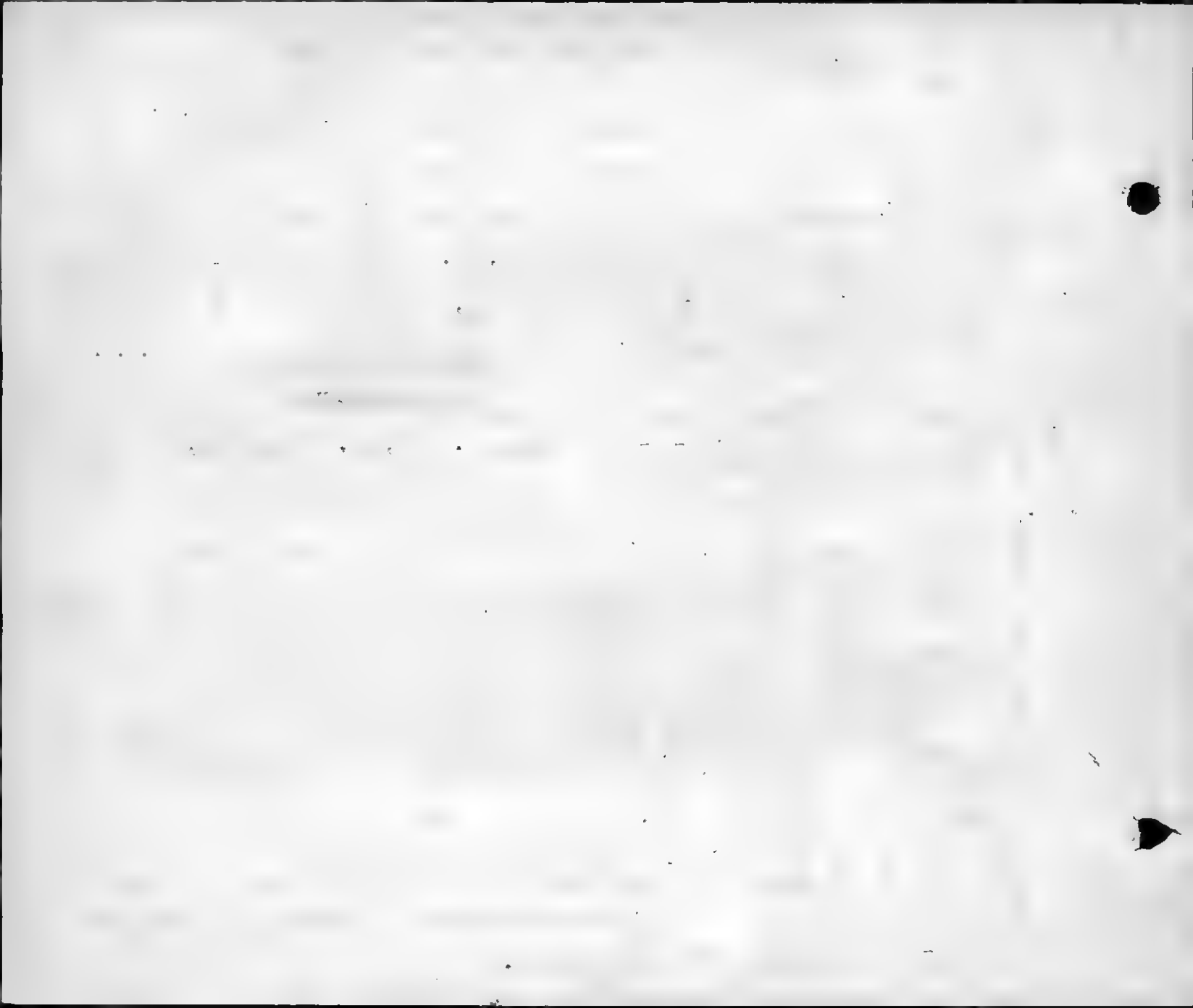
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10773

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Rhode Island b. COUNTY Providence	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woonsocket	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS 474 Fairmount Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Fish & Game Club		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARMAND Middle JOSEPH Last PAGE, SR.		4. DATE OF DEATH Month September Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	11. BIRTHPLACE (State or foreign country) QUEBEC CANADA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LOUIS PAGE	
14. MOTHER'S MAIDEN NAME Vadeboncouer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W W I	
16. SOCIAL SECURITY NO. 036-05-0773		17. INFORMANT Address Armand J. Page, Jr. Funkstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease DUE TO (c) Coronary Artery Disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A. M. Smith		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. E. H. Smith		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/20/60	
22c. NAME OF CEMETERY OR CREMATORY Precious Blood Cemetery		22d. LOCATION (City, town, or county) (State) WOONSOCKET RHODE ISLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Charles M. Rouzer		24a. REC'D BY REGISTRAR DATE SEP 23 '60	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the date. State, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10780

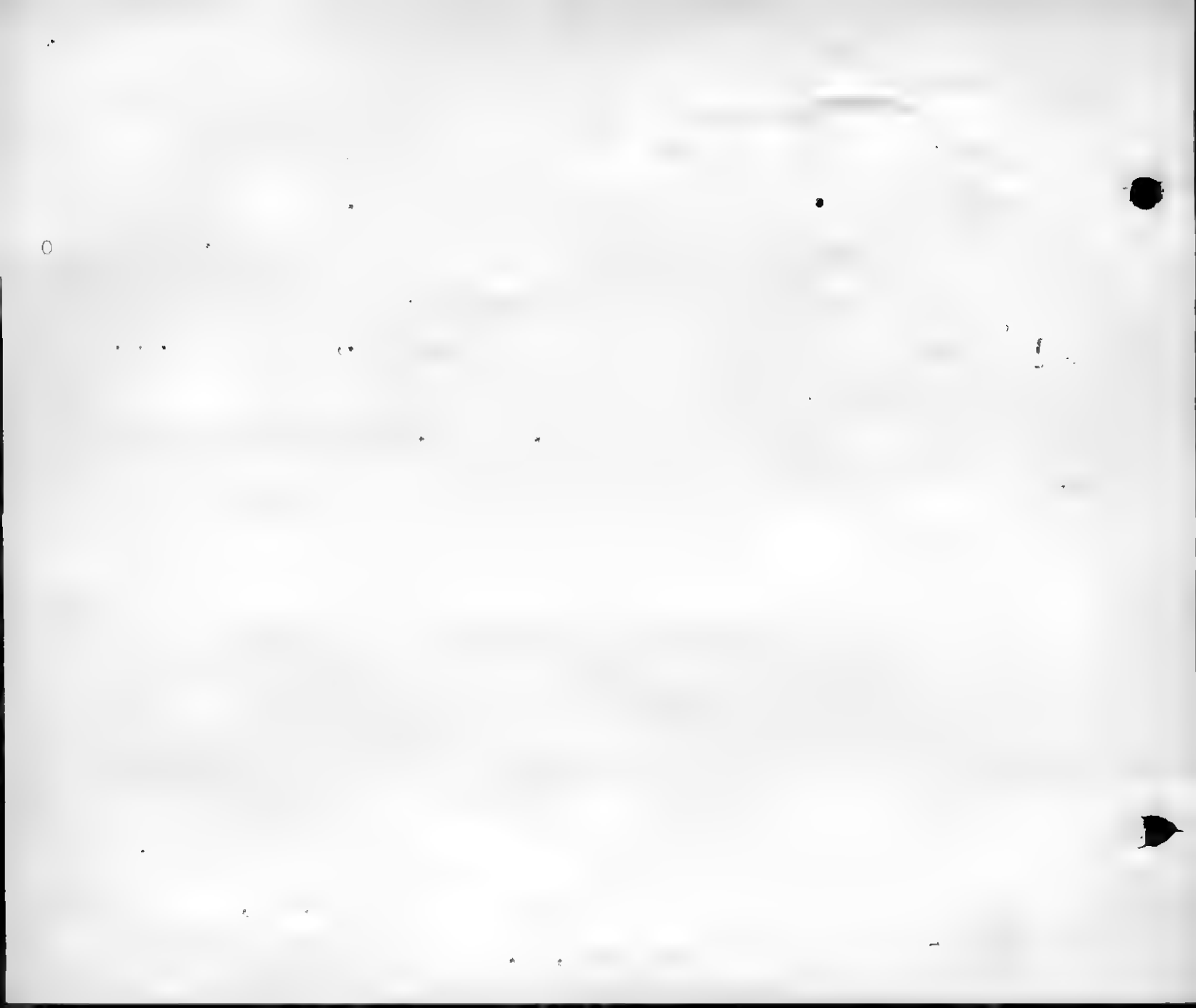
10774

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>711 Oak Hill Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>DORA</u> Last <u>POOLE</u>				4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 14, 1875</u>	
9. AGE (In years lost birthday) yrs. <u>84</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Co., Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Valentine Brewer</u>				14. MOTHER'S MAIDEN NAME <u>Ada ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Dr. Ernest F. Poole</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>general arteriosclerosis & arterio-</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>schrotti heart disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcified heart & lungs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 6, 1957</u> to <u>Sept 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 20, 1960</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				22d. ADDRESS <u>217 West Washington Street</u>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/26/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Syter - Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>	
				25b. REG-ISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

090

1

M

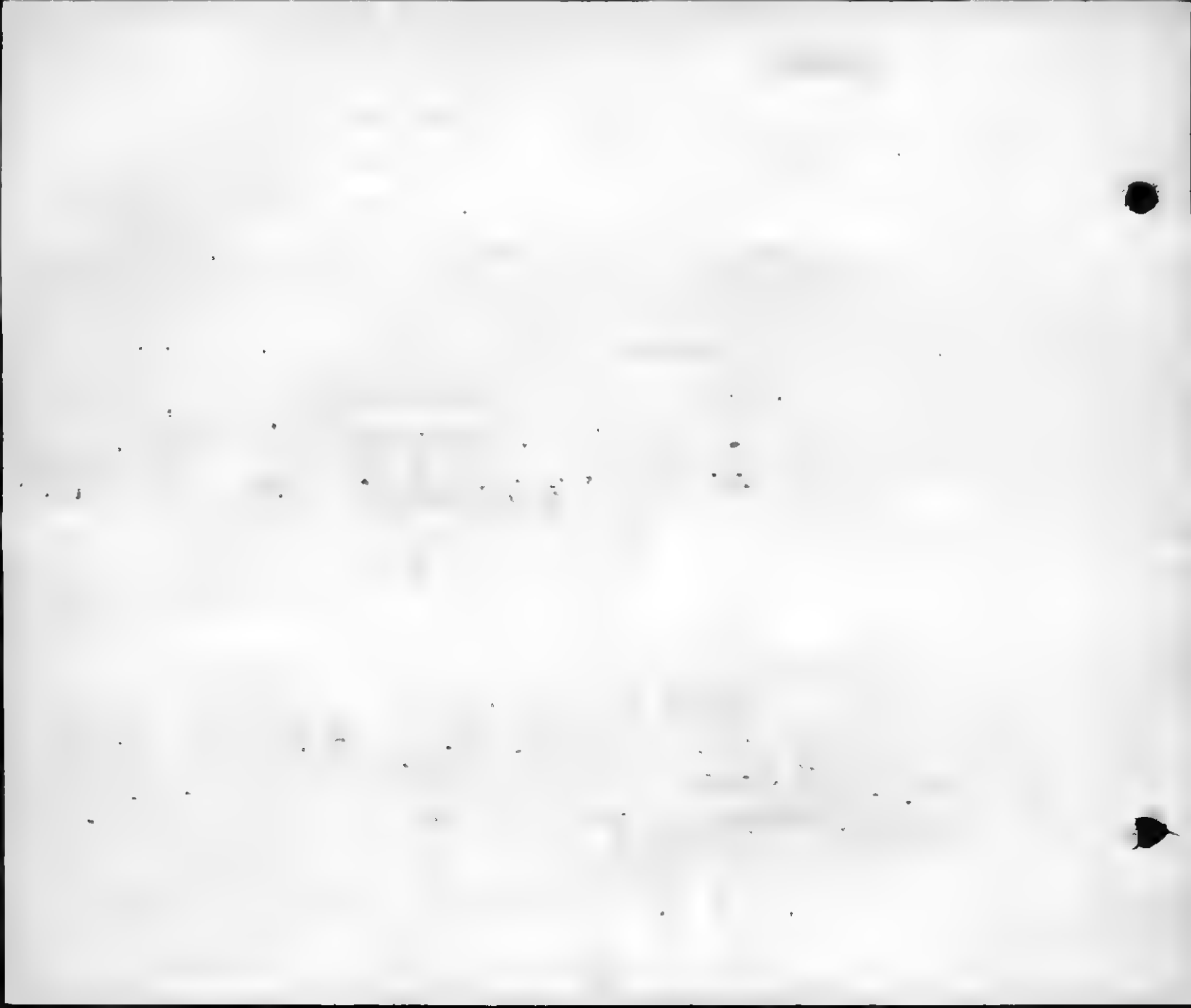


may be retd. by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10813
CERTIFICATE OF DEATH

10775

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport				c. LENGTH OF STAY IN 1b 8 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woburn Manor Boarding Home				e. STREET ADDRESS 136 W. Potomac Street			
3. NAME OF DECEASED (Type or print) First William Middle G Last Reed				4. DATE OF DEATH Month Sept. Day 8 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13 1886	9. AGE (In years last birthday) yrs 74	IF UNDER 1 YEAR Months 5 Days 25 Hours Min. 		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME William W. Reed				14. MOTHER'S MAIDEN NAME Mary Donneley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215 09 7346		17. INFORMANT Mr. John Corby			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to (c) 				INTERVAL BETWEEN ONSET AND DEATH See my card before time of death			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9/8/60		20f. (City or town) (County) (State) Williamsport Maryland
21. I certify that (I) (this hospital) attended the deceased from 9/8/60 to 9/9/60 , that (I) (we) last saw the deceased alive on 9/8/60 , and that death occurred at 9:37 M. from the causes and on the date stated above.							
22a. SIGNATURE Leah Spring				22b. DATE SIGNED 9/9/60		22c. PHYSICIAN'S NAME (Type) Leah Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 10-60		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
23d. LOCATION (City, town, or county) (State) Williamsport Maryland				25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md							

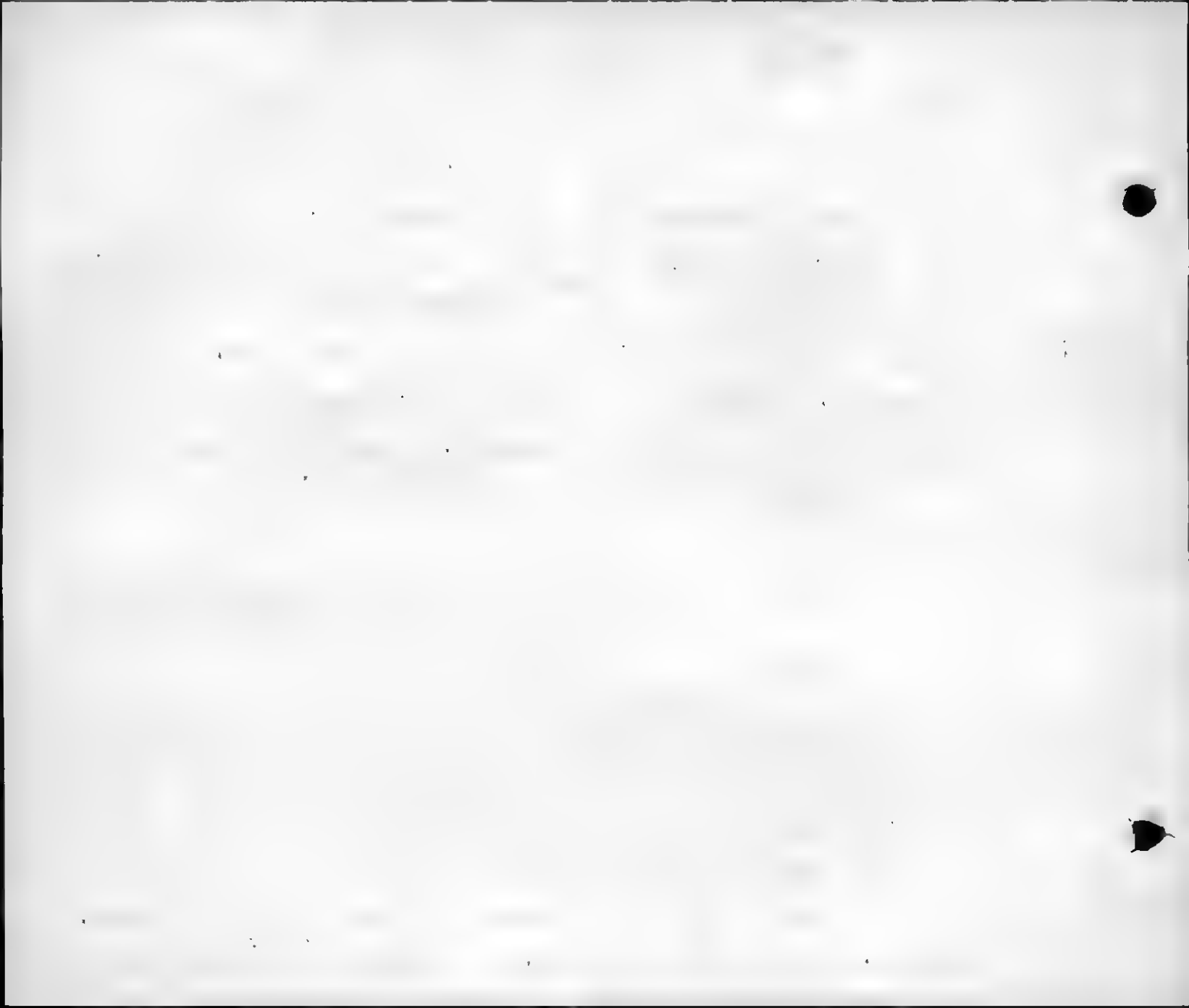


1
TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death

VR A15 (4)
15M 9/59

10781
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10776
CERTIFICATE OF DEATH 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 745 Spruce St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLTON NELSON REEDER		4. DATE OF DEATH September 4 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4 1960 9. AGE (In years last birthday) yrs Months Days Hours Min 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles N. Reeder Jr		14. MOTHER'S MAIDEN NAME Virginia Curry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles N. Reeder Jr		Address 745 Spruce St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 782.0 Fracture of skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 12 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/4 19 60 to 9/4 19 60 , that (I) (we) last saw the deceased alive on 9/4 19 60 and that death occurred at 12 PM , from the causes and on the date stated above.			
22a. SIGNATURE Richard A. Young		22b. DATE SIGNED 9/6/60	
22c. PHYSICIAN'S NAME (Type) Richard A. Young		22d. ADDRESS Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/5/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR SEP 9 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Charles S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10777

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR ROAD, RURAL</u>	
c. LENGTH OF STAY IN 1b <u>1-HOUR</u>		d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>PEAK OF PANGBORN CORP. PLANT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN LUTHER RIDENOUR</u>	4. DATE OF DEATH <u>SEPT. 19 - 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 21 - 1942</u>
9. AGE (in years last birthday) <u>18 yrs</u>	10. IF UNDER 1 YEAR	11. BIRTHPLACE (State or foreign country) <u>WASH. CO. MD.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT AT GAS STATION</u>	10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WELTY RIDENOUR</u>	14. MOTHER'S MAIDEN NAME <u>LEILA SMITH</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>218-40-2789</u>	17. INFORMANT <u>WELTY RIDENOUR BOONSBORO MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Electrocuted while handling electric drill.</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p.m. <u>9-19-60</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>View Street</u>	20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. Ditto</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 22 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Burt</u>	24a. REC'D BY REGISTRAR <u>DATE OCT 3 '60</u>		
	24b. REGISTRAR'S SIGNATURE <u>John R. Burt</u>		

TO DEPUTY

VS. A15ME
5M 2/57

ICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. DITTO

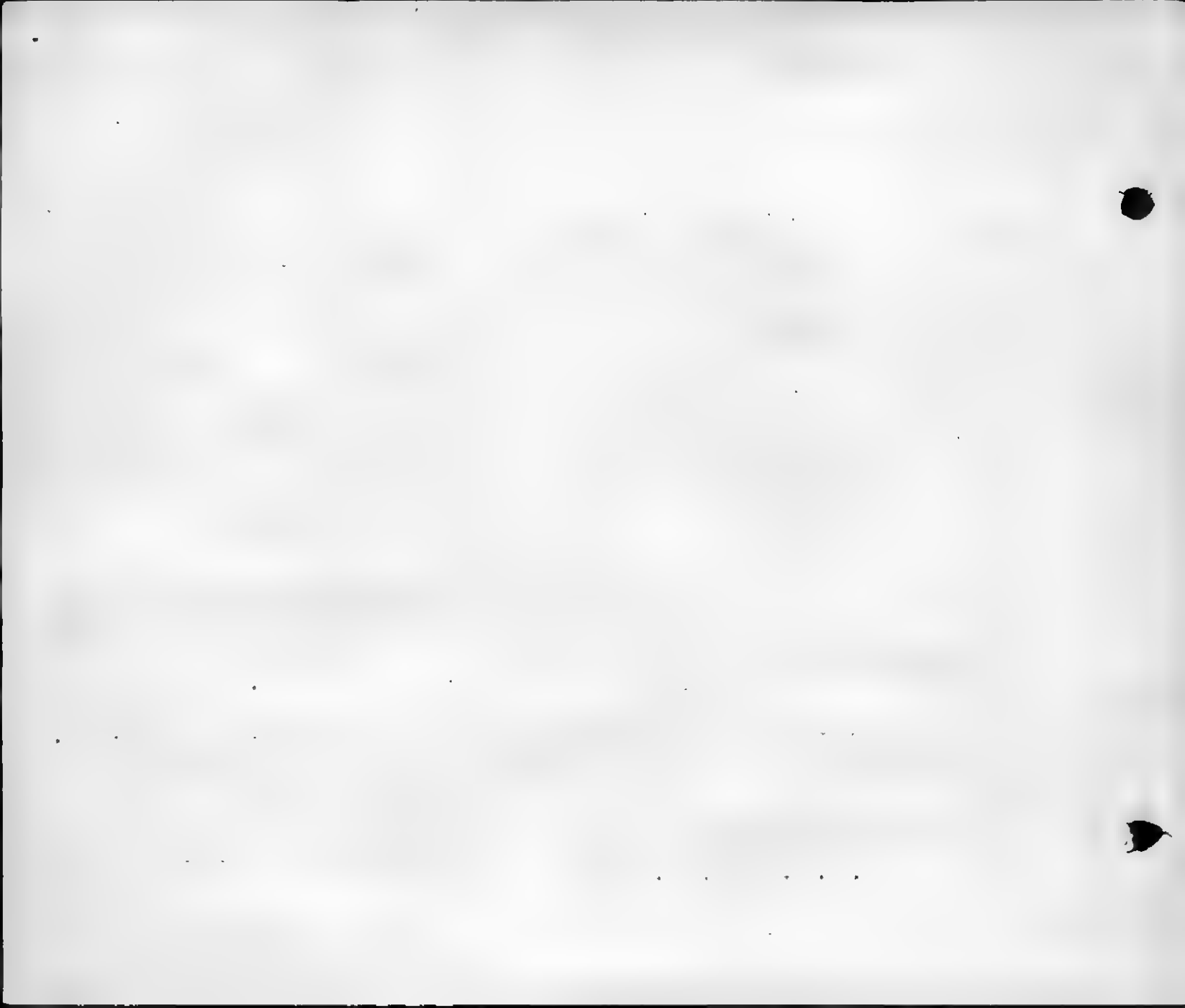
M

I

21

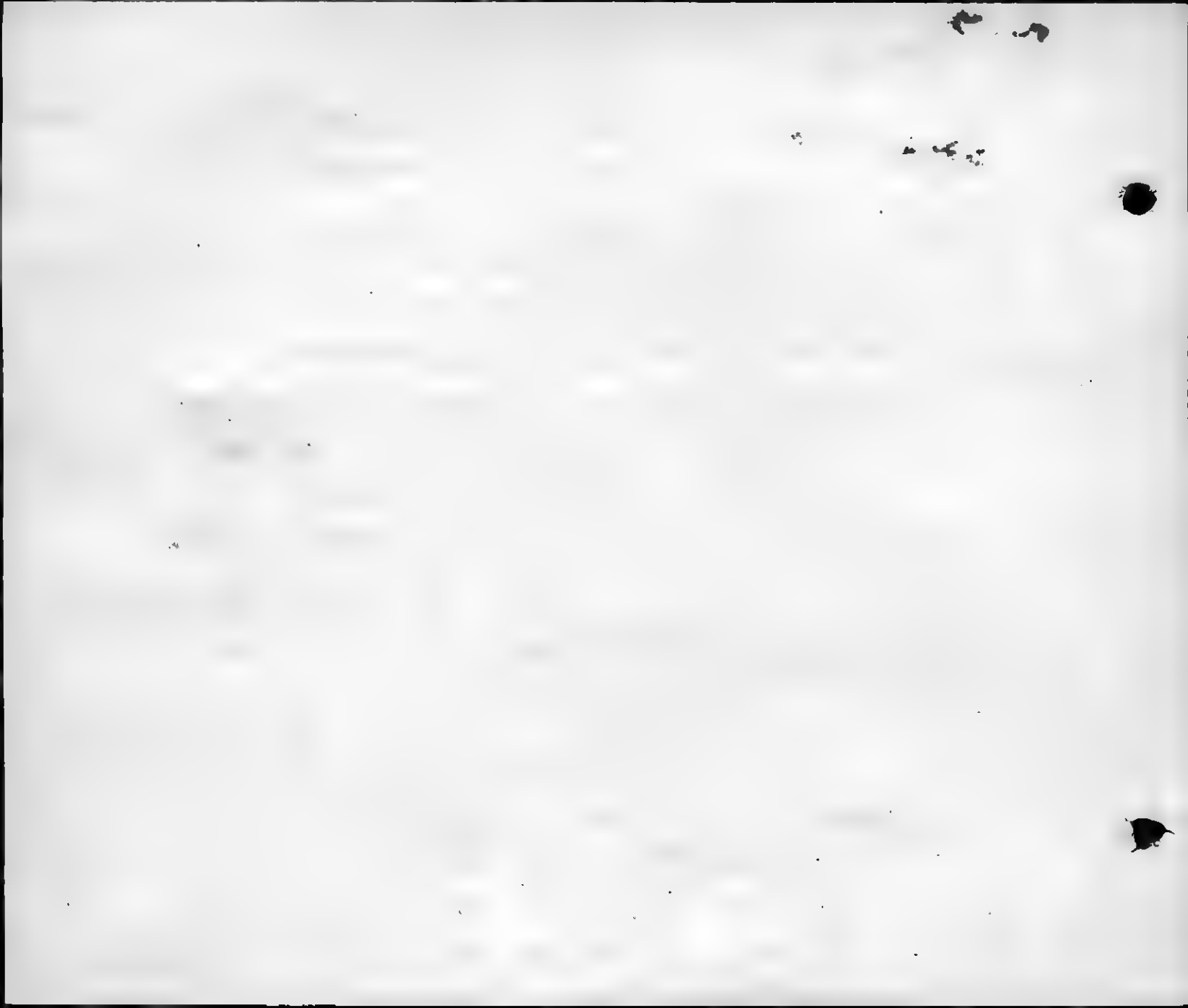
2

OP



10778

MEDICAL CERTIFICATION



10779

10742

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Penna.		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jenkintown		71	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Apt. 415 The Benson East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle Whiting Last Shelly				4. DATE OF DEATH Month Sept. Day 20 Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1892	
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 74 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife and,				10b. KIND OF BUSINESS OR INDUSTRY Vice Pres. W.H. Whiting Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William H. Whiting				14. MOTHER'S MAIDEN NAME Caroline L. Yager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 202-07-1080		17. INFORMANT Mrs. Robert A. Mack, Concord, Massachusetts			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis with Rt. Hemiplegia 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease with Auricular Fibrillation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-20-60, to 9-20-60, 1960, that I last saw the deceased alive on 9-20-60, 1960, and that death occurred at 7:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dalton M. Wolty, M.D. 998 Potomac Avenue 9-20-60							
ACTUAL SIGNATURE Dalton M. Wolty, M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/1960		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Horne				ADDRESS Waynesboro, Pa.		24a. REC'D BY REGISTRAR DATE SEP 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Horne							

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
M

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

10803

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10780

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u>			
c. LENGTH OF STAY IN 1b <u>13 days</u>				d. STREET ADDRESS <u>NONE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF <u>Ada</u> First <u>V.</u> Middle <u>Smith</u> Last				4. DATE OF DEATH <u>September 13</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2,</u> 1877	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL TEACHER</u>		11. BIRTHPLACE (State or foreign country) <u>Big Spring</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Mahala Brewer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MISS HELEN K. SMITH</u> Address <u>BIG SPRING, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with Hemiplegia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>15 years</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> <u>CARCINOMA OF THE RECTUM</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 28, 1960</u> to <u>September 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 13, 1960</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Archie Robert Cohen</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 14, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				22d. ADDRESS <u>Clear Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL, CLSPG. MD.</u>		23d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>CLEAR SPRING, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

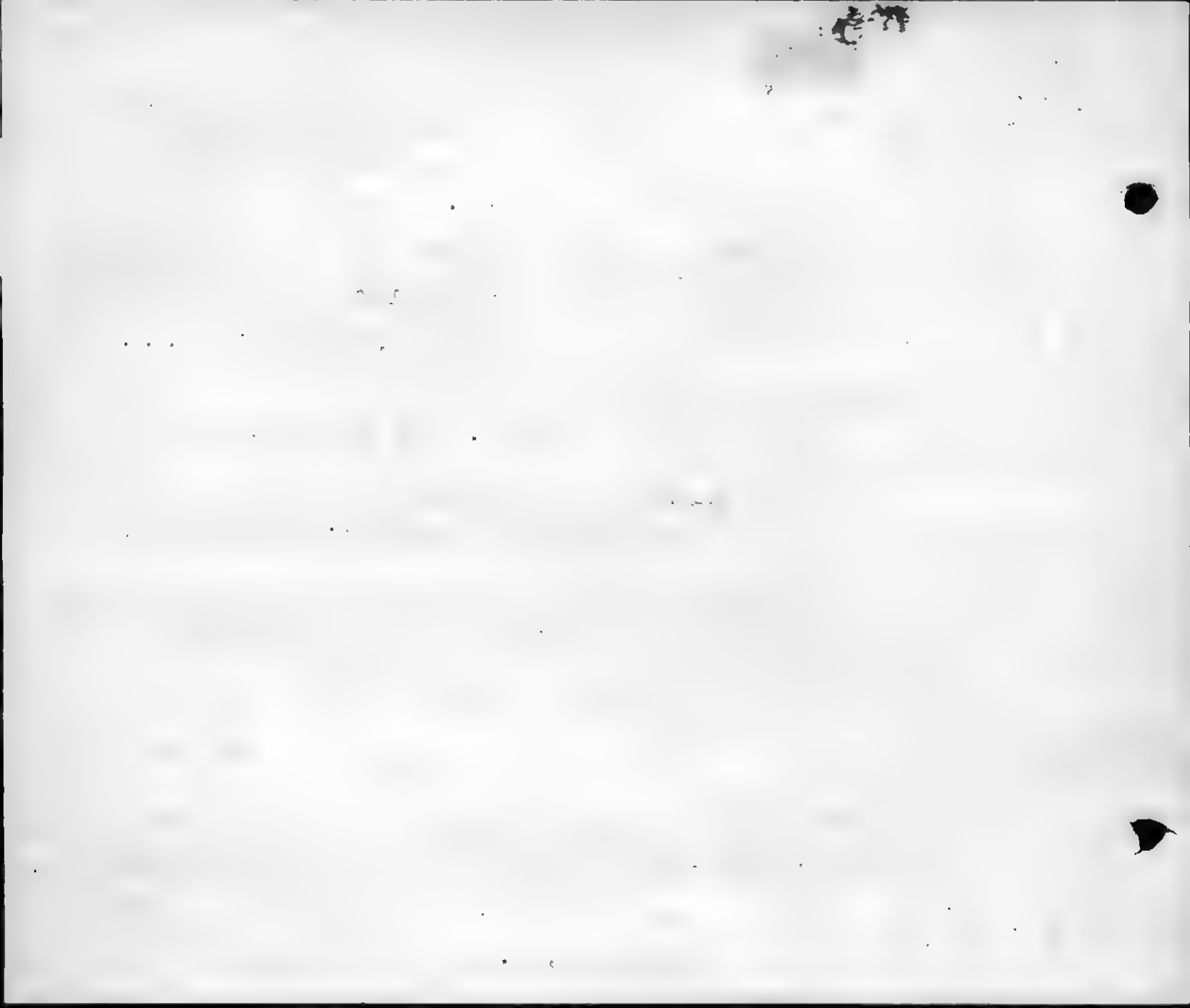
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10781

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b most of life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gertrude Edith SMITH				4. DATE OF DEATH 9 30 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 4, 1882	
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Oxford, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Abram Stambaugh				14. MOTHER'S MAIDEN NAME Emily Kepner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT James W. Smith Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subacute Pyelonephritis DUE TO Rheumatoid arthritis, multiple. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 122 (c)				INTERVAL BETWEEN ONSET AND DEATH 6 months 13 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emboli. Coronary atherosclerosis							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept. 17, 1960 to Sept. 30, 1960 , that (I) (we) last saw the deceased alive on Sept. 30, 1960 and that death occurred on Sept. 30, 1960 , from the causes and on the date stated above.							
22a. SIGNATURE Young E. Chun M.D.				22b. DATE SIGNED Sept. 30, 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Young E. Chun				22d. ADDRESS 1500 Penna Ave, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/1960		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				25a. REC'D BY REGISTRAR OCT 3 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	
25c. ADDRESS Hagerstown, Md.							



TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

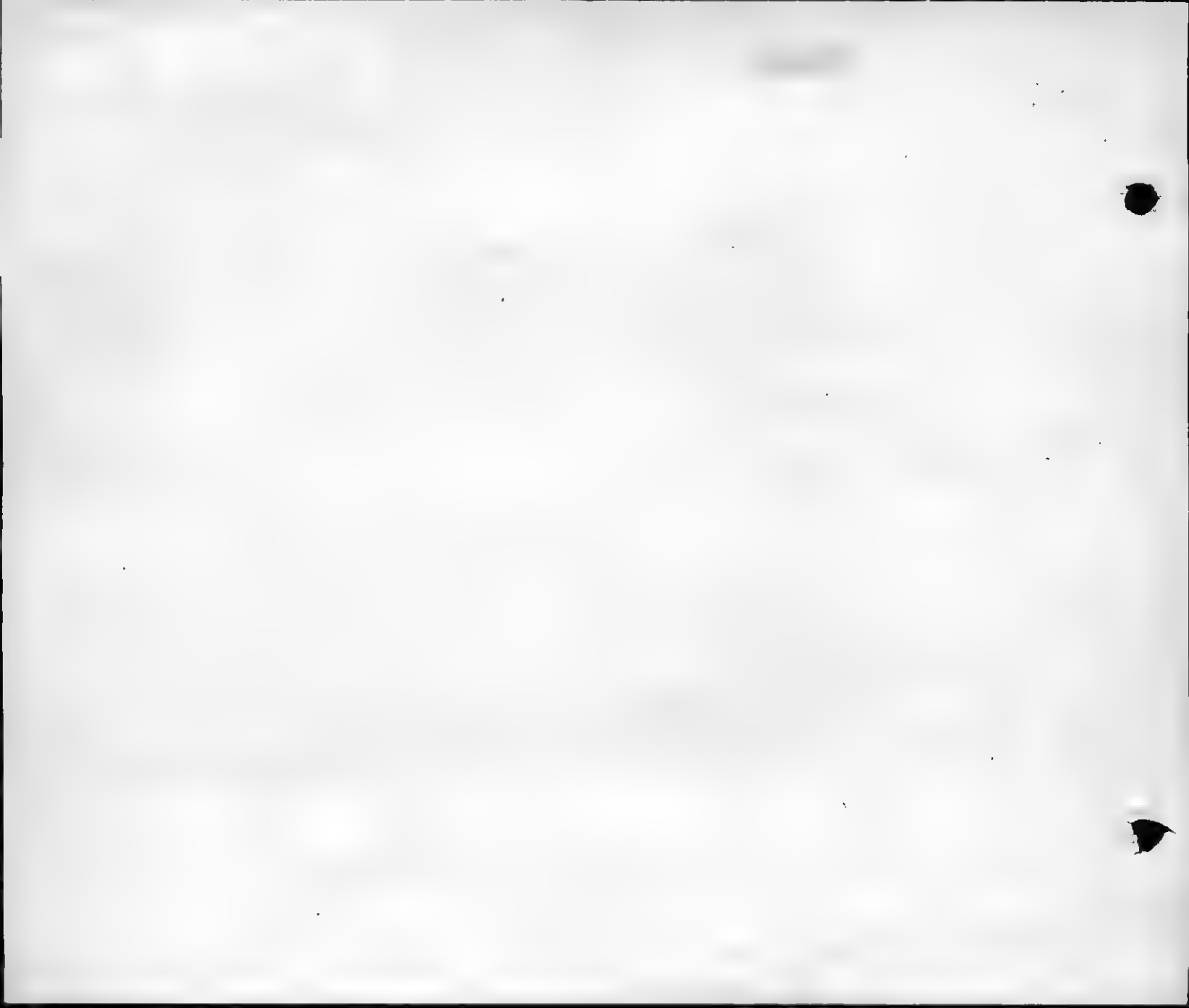
VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10801
CERTIFICATE OF DEATH

10782

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Booneshoro				c. LENGTH OF STAY IN 1b 6 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder's Nursing Home				e. STREET ADDRESS 43 E. Washington St.			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MYRTLE SPRECHER				4. DATE OF DEATH Month Sept. Day 22 Year 19 60			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 12, 1872	9 AGE (In years last birthday) 88 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Shanktown, Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John T. Weaver				14 MOTHER'S MAIDEN NAME Ann Mary Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give year or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Elsie Everitt 43 E. Washington St. Hagerstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis with							years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) decompensation of heart							
(c) Cancer of neck							4 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from April 10, 1960 to Sept 22 1960 , that (I) (we) last saw the deceased alive on Sept 22 1960 , and that death occurred at 4 P. M. from the causes and on the date stated above.							
22a. SIGNATURE G. W. Weaver				22b. DATE SIGNED 9/24/60			
22c PHYSICIAN'S NAME (Type) G. W. Weaver				22d. ADDRESS Booneshoro Md.			
23a BURIAL, CREMATON, REMOVA (Specify) Burial		23b DATE THEREOF 9/25/60		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (City, town, or county) (State) Clearspring Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		25a REC'D BY REGISTRAR DATE SEP 27 '60	
				25b REGISTRAR'S SIGNATURE Arthur L. Kraus			

Wm. G. Howard



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

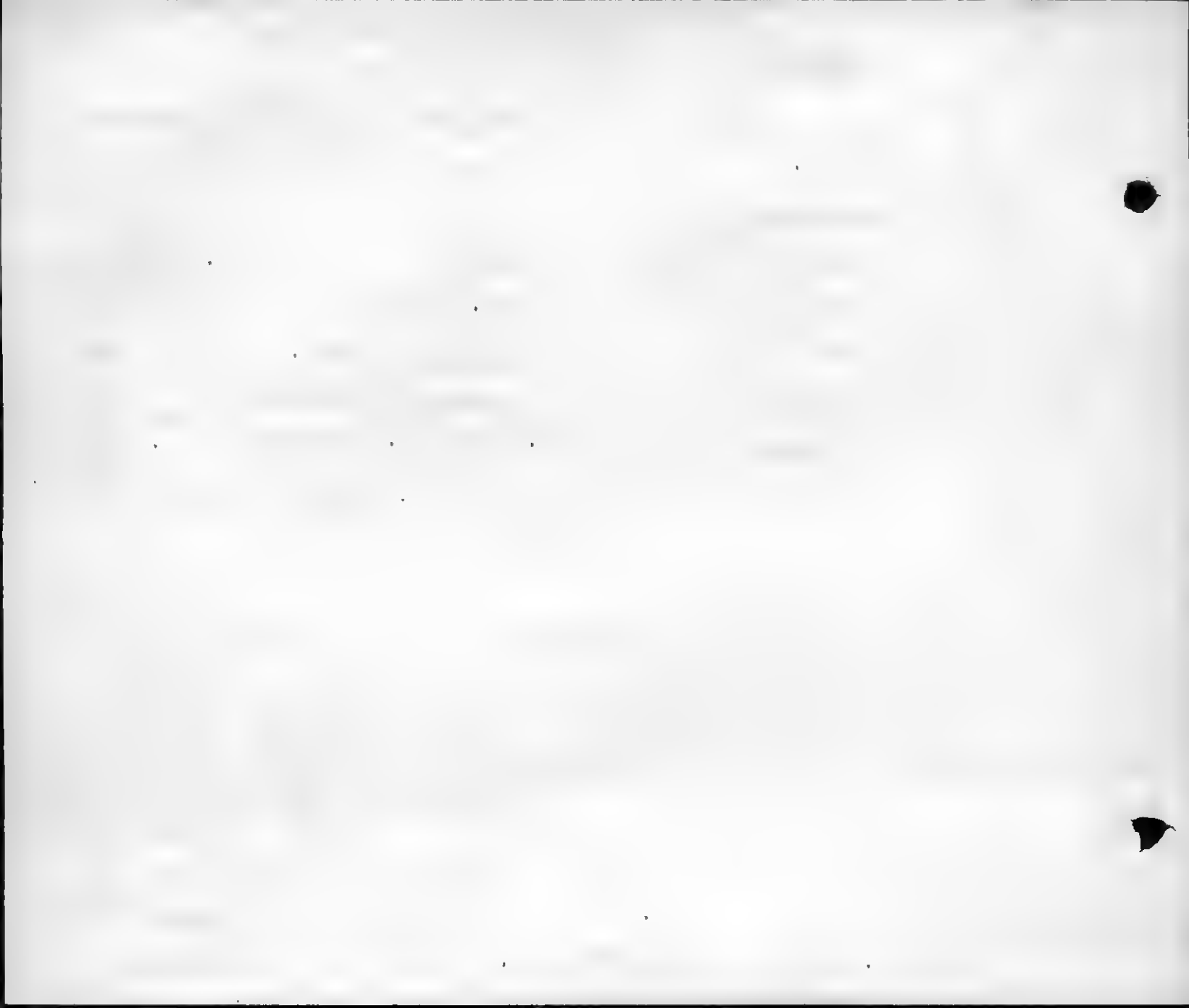
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10783

10814

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Rt. #4 c. LENGTH OF STAY IN 1b Hagerstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadforeing Road				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland Washington b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAUL ELMER SPRECHER First Middle Last			4. DATE OF DEATH Sept. 9 1960 Month Day Year				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Dec. 15, 1892		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 8 Days 24 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Willsons Wash. Co Md			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Sprenger					
14. MOTHER'S MAIDEN NAME Catherine Zentmyer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Myrtle L. Sprecher Address Hagerstown Md. Rt. #4					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 430 Coronary Occlusion DUE TO (b) Gen Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-1-60 to 9-9-60 that (I) (we) last saw the deceased alive on 9-7-60 and that death occurred 9-9-60 from the causes and on the date stated above							
22a. SIGNATURE A. E. W. Dittus Jr.		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) A. E. W. Dittus Jr.			
22d. ADDRESS Hagerstown Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery			
23d. LOCATION (City, town, or county) Wash Co Md		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. ADDRESS Hagerstown Md.		24b. REC'D BY REGISTRAR SEP 13 '60			
24c. REGISTRAR'S SIGNATURE Charles S. Kline		24d. (State)					



10815
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10784

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN			
c. LENGTH OF STAY IN 1b 33 YEARS				d. STREET ADDRESS 239 EAST BALTIMORE ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 239 EAST BALTIMORE ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET F. STEEN				4. DATE OF DEATH SEPTEMBER 25, 1960			
5. SEX FEMALE				6. COLOR OR RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED				8. DATE OF BIRTH DECEMBER 18, 1877			
9. AGE (In years last birthday) 82 yrs.				10. IF UNDER 1 YEAR Months 9 Days 7 Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
11. BIRTHPLACE (State or foreign country) WELSH RUN				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHRISTIAN MARCOTTE				14. MOTHER'S MAIDEN NAME NANCY SHAFER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT JOHN W. STEEN				Address FUNKSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease. Years DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1960 to Sept. 25, 1960 , that (I) (we) last saw the deceased alive on Sept. 23, 1960 , and that death occurred at 5 P M, from the causes and on the date stated above							
22a. SIGNATURE R.A. Bell, M.D.				22b. DATE SIGNED 9-27-60			
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				22d. ADDRESS Hagerstown, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF SEPT. 28, 1960			
23c. NAME OF CEMETERY OR CREMATORY FUNKSTOWN CEMETERY				23d. LOCATION (City, town, or county) (State) FUNKSTOWN WASH. CO. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Best				25a. REC'D BY REGISTRAR OCT 3 '60			
ADDRESS BOONSBORO MD				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

119 N. POTOMAC ST.

1



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

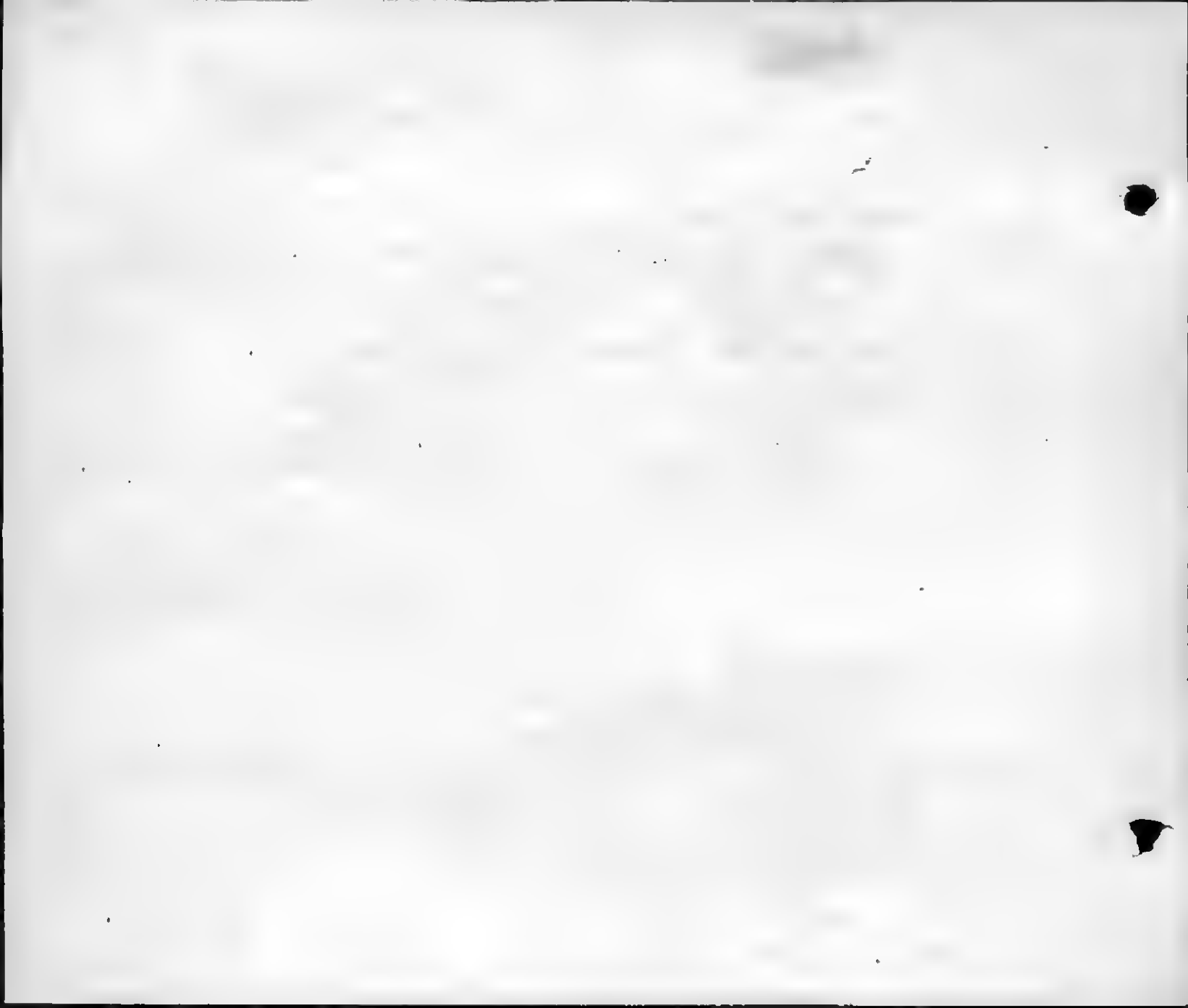
302

10785

10786

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 20 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 534 Pangborn Blvd				d. STREET ADDRESS 534 Panbborn Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last STONEBRAKER				4. DATE OF DEATH Month September Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28 1881	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 5 Days 14 Hours 14 Min.		11. IF UNDER 24 HRS Months 5 Days 14 Hours 14 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer Retired				10b. KIND OF BUSINESS OR INDUSTRY Downsville Wash Co Md.			
11. BIRTHPLACE (State or foreign country) Downsville Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME D. Huyett stonebraker				14. MOTHER'S MAIDEN NAME Frances Rowland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-16-5314		17. INFORMANT Mrs Viola H. Stonebraker	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 534 Pangborn Blvd Hagerstown Md 5 min 1 yr				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-2-1960 to 9-2-1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred over M, from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison				22b. DATE SIGNED 9-3-60		22c. PHYSICIAN'S NAME (Type) Paul Harrison, M.D.	
22d. ADDRESS 315 N. Potomac St., Hagerstown, Md.				22e. ADDRESS 315 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/5/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24a. REC'D BY REGISTRAR SEP 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kinn	

MEDICAL CERTIFICATION



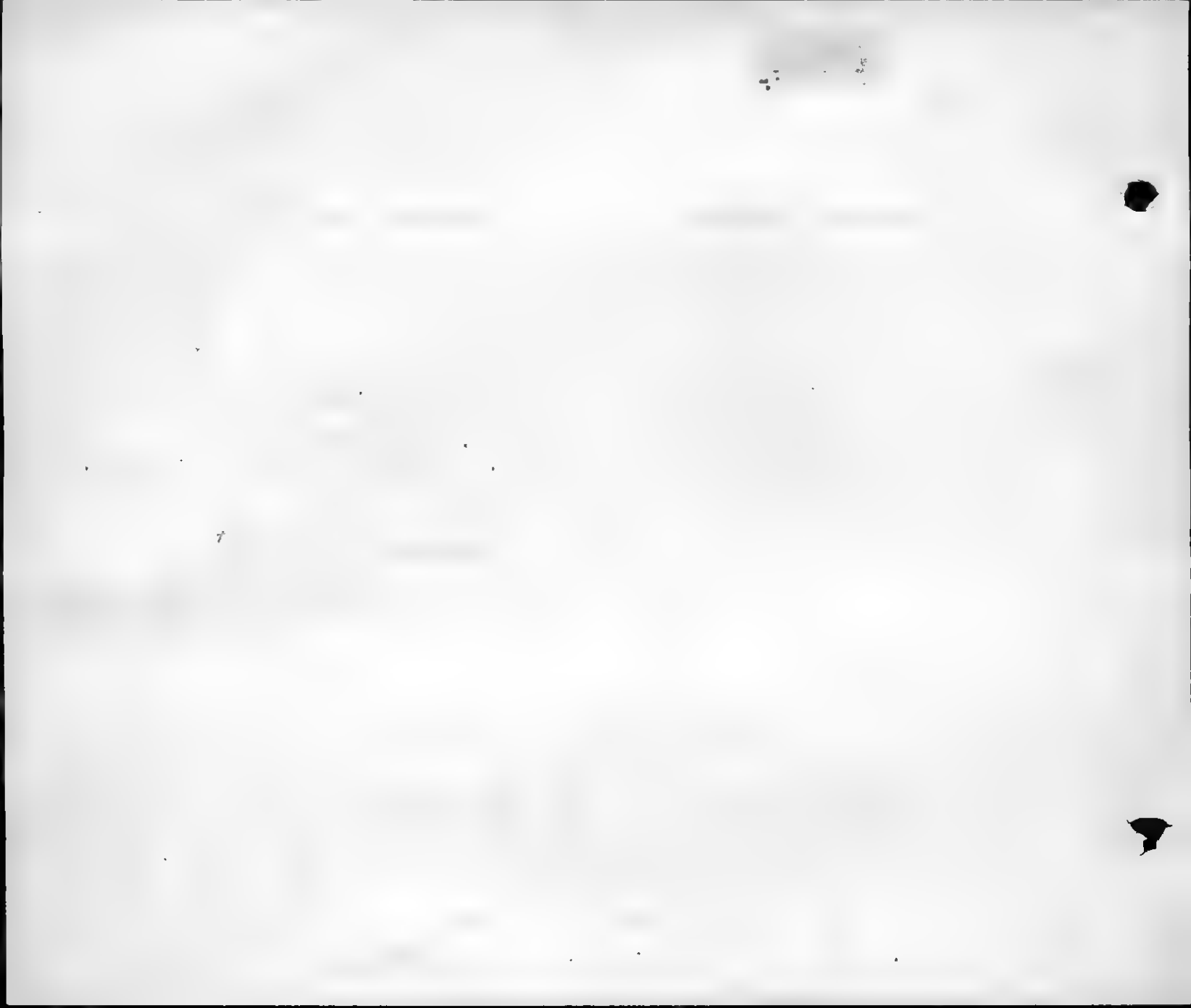
1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10787
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302
10786

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash county hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JANE ELIZABETH STOTELMYER				4. DATE OF DEATH Month Sept Day 14 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 4 1960	9. AGE (In years last birthday) yrs 2	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS Days 10	Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Stotelmyer Jr				14. MOTHER'S MAIDEN NAME Frances Whorton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lewis V. Stotelmyer Jr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 253.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Systemic DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE Richard A. Young				22b. DATE SIGNED 9/15/60			
22c. PHYSICIAN'S NAME (Type) Richard A. Young				22d. ADDRESS 101 King St. Hagerstown Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE SEP 19 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kenna	

2081309XV4



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

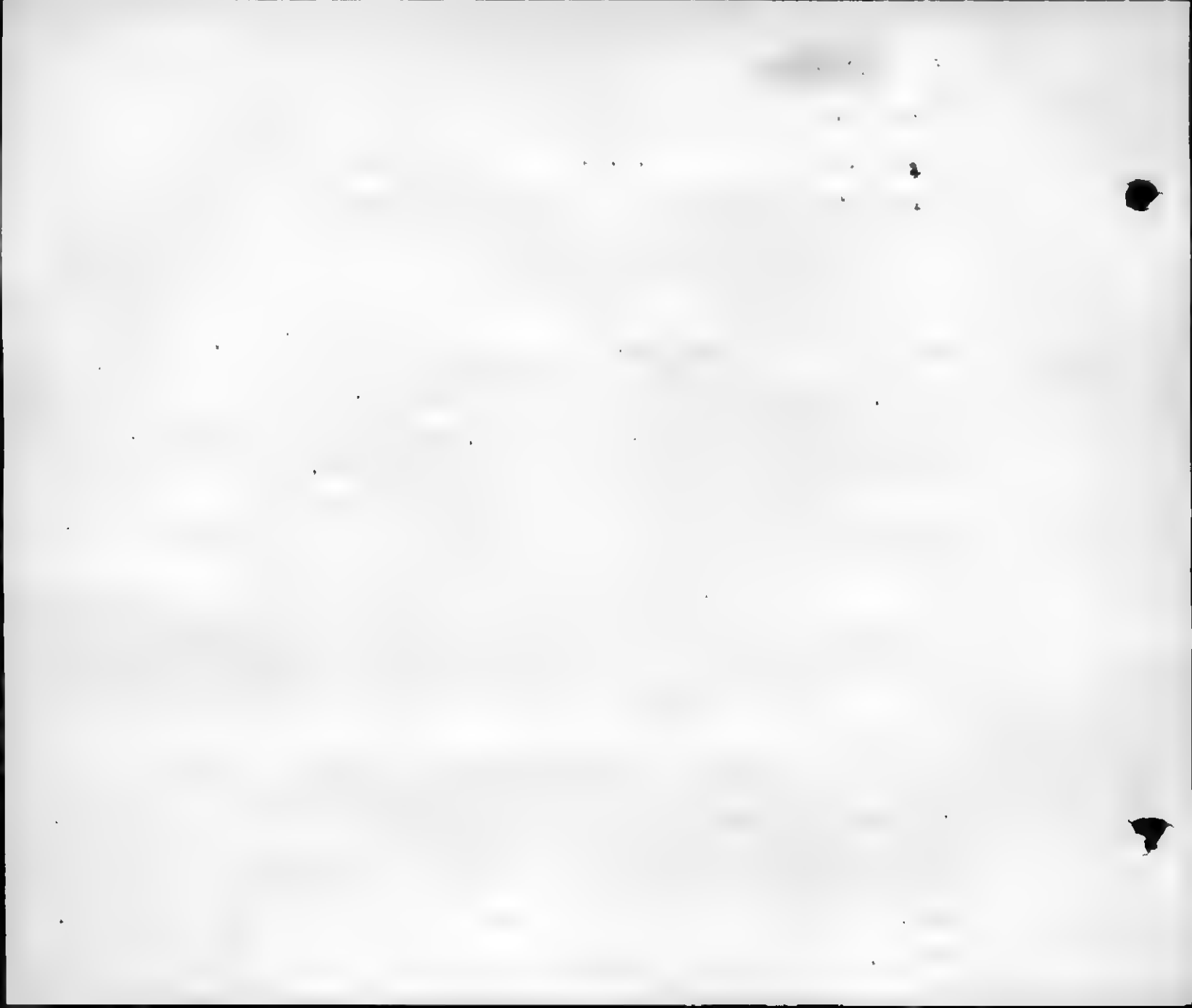
10788

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

10787

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1310 Bryan Place			
3. NAME OF DECEASED (Type or print) First CECILE Middle ELLA Last STOTLER				4. DATE OF DEATH Month Sept Day ember 28 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21 1895		9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Stotler				14. MOTHER'S MAIDEN NAME Lutie V. Summers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Daniel O. Stotler 147 Belview Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dementia - right DUE TO (b) breast with metastasis to chest DUE TO (c) Spine - right femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 4 1960 to Sept 28 1960 , that (I) (we) last saw the deceased alive on Sept 27 1960 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Dittus III, M.D.				22b. DATE SIGNED 9/27/60		22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTUS III, M.D.	
22d. ADDRESS 217 WEST WASHINGTON ST.				22e. REC'D BY REGISTRAR OCT 3 '60		22f. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown				25. ADDRESS Md			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

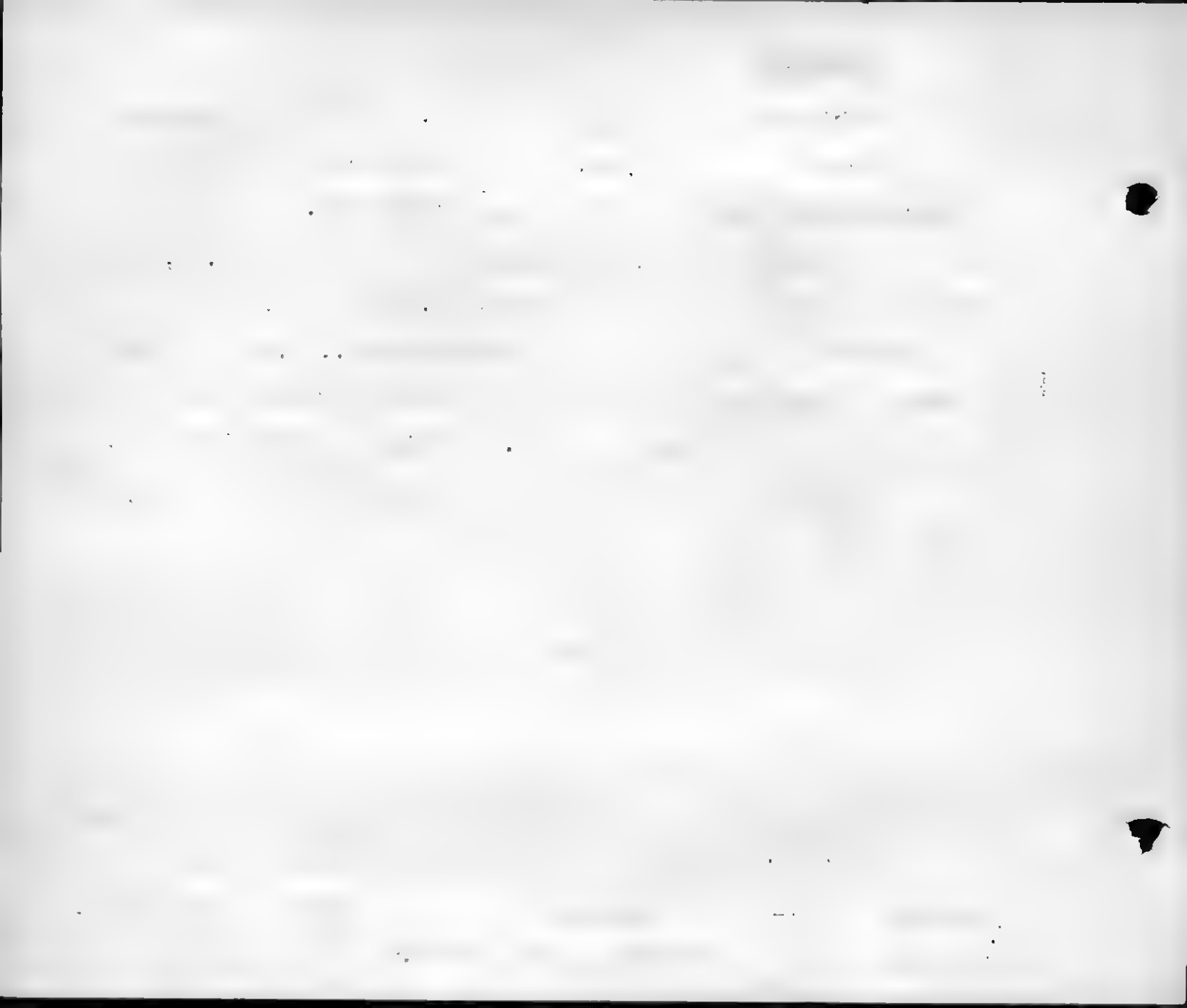
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10816

10788

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 010			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Rest Home				d. STREET ADDRESS 103 Race St.			
3. NAME OF DECEASED (Type or print) First Mary Middle Ida Last Stotler				4. DATE OF DEATH Month Sept. Day 8, Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1867	
9. AGE (In years lost birthday) 92 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Berkeley Co., W.Va.			
13. FATHER'S NAME Thomas Myers				14. MOTHER'S MAIDEN NAME Sarah Nornton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO None			
17. INFORMANT Mrs. B. Britt				Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from June 60 to Sept 8, 1960 , that (I) (we) last saw the deceased alive on Aug 28, 1960 , and that death occurred at 11 M, from the causes and on the date stated above							
22a. SIGNATURE Dr. B.M. Schindler				22b. DATE SIGNED Sept 10/60			
22c. PHYSICIAN'S NAME (Type) Dr. B.M. Schindler				22d. ADDRESS 43 Greene Street Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-60		23c. NAME OF CEMETERY OR CREMATORY Greenway		23d. LOCATION (City, town, or county) (State) Berkeley Springs, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas P. Hester				25a. REC'D BY REGISTRAR Berkeley Springs, W. Va.		25b. REGISTRAR'S SIGNATURE SEP 14 '60	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weverton		c. LENGTH OF STAY IN 1b 0	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Route #340		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook (Rural)	
3. NAME OF DECEASED (Type or print) First Middle Last WAYNE WILLIAM TRIBBY		4. DATE OF DEATH Month Day Year September 8, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1942
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Y.M.C.A.	
11. BIRTHPLACE (State or foreign country) Knoxville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin West Tribby		14. MOTHER'S MAIDEN NAME Mabel Loretta Deaner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-40-2897	
17. INFORMANT Address Mrs. Levin Tribby RFD# 1, Knoxville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck stone buttress while driving west on State R # 340	
20c. TIME OF INJURY Month, Day, Year Hour Min. P. M. 11:50 9-8-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State R # 340 Weverton, Washington, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DATE SIGNED 9-9-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/60	
22c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cemetery, Brownsville, Md.		22d. LOCATION (City, town, or county) (State) Brownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Donald Cackles		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
24b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

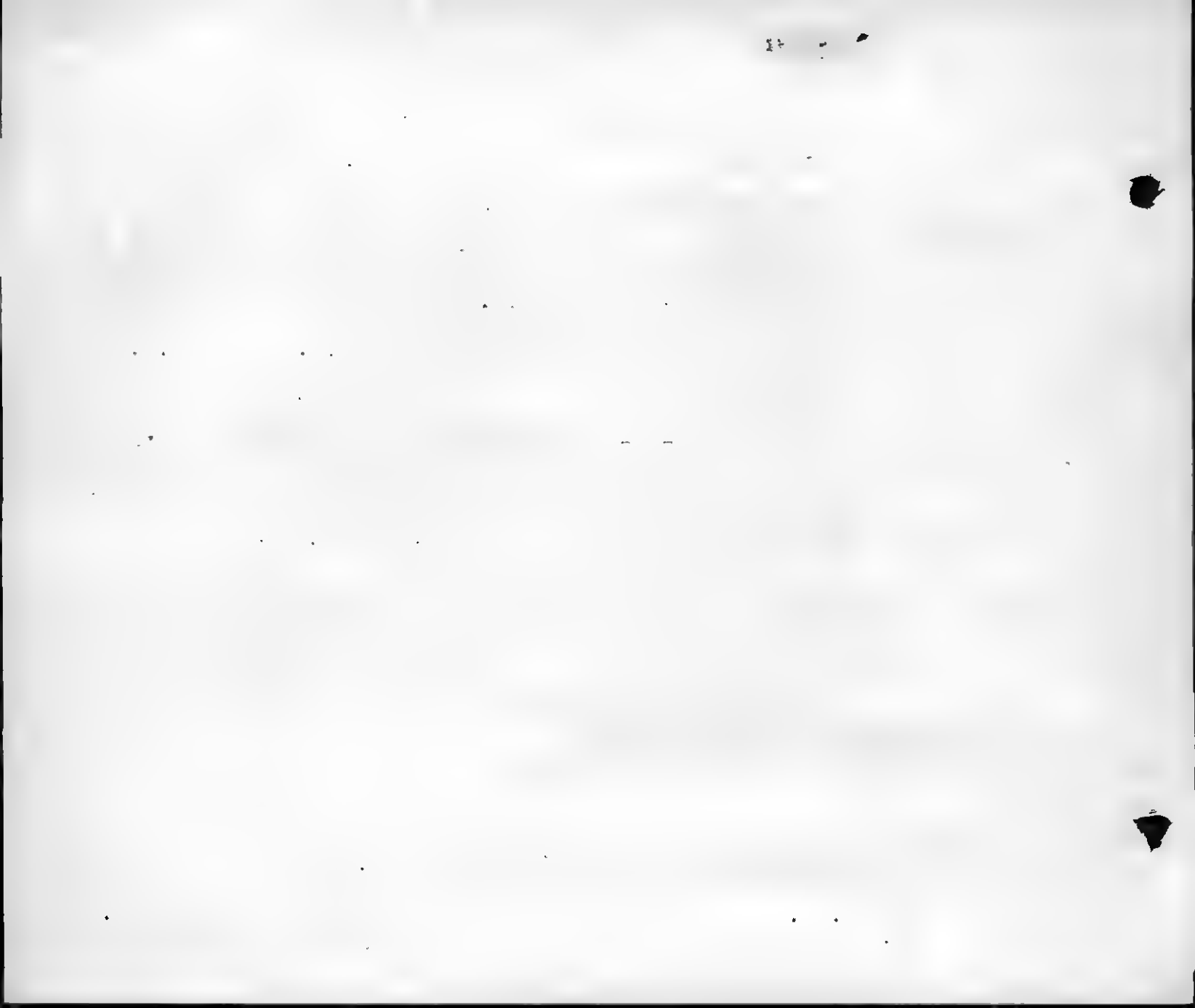
VR A15 (4)
15M 9/59

10789

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10790

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland	
f. STREET ADDRESS Hancock Maryland		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Paul Last Turner		4. DATE OF DEATH Month 9 Day 15 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9.8.1910
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 15 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Harrisonburg VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Turner		14. MOTHER'S MAIDEN NAME Catherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 094-10-9874	
17. INFORMANT Mildred J Turner Hancock Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Infarction of myocardium DUE TO (b) Arteriosclerotic coronary thrombosis DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 8 hour Days Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 8, 1960 to Sept 15, 1960 , that (I) (we) lost saw the deceased alive on Sept 15, 1960 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE R. S. Stauffer		22b. DATE SIGNED Sept. 16, 1960	
22c. PHYSICIAN'S NAME (Type) R. S. STAUFFER		22d. ADDRESS Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9.18.60	
23c. NAME OF CEMETERY OR CREMATORY Oliver Grove Cemetery		23d. LOCATION (City, town, or county) (State) Oldtown Allegany Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DATE SEP 19 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

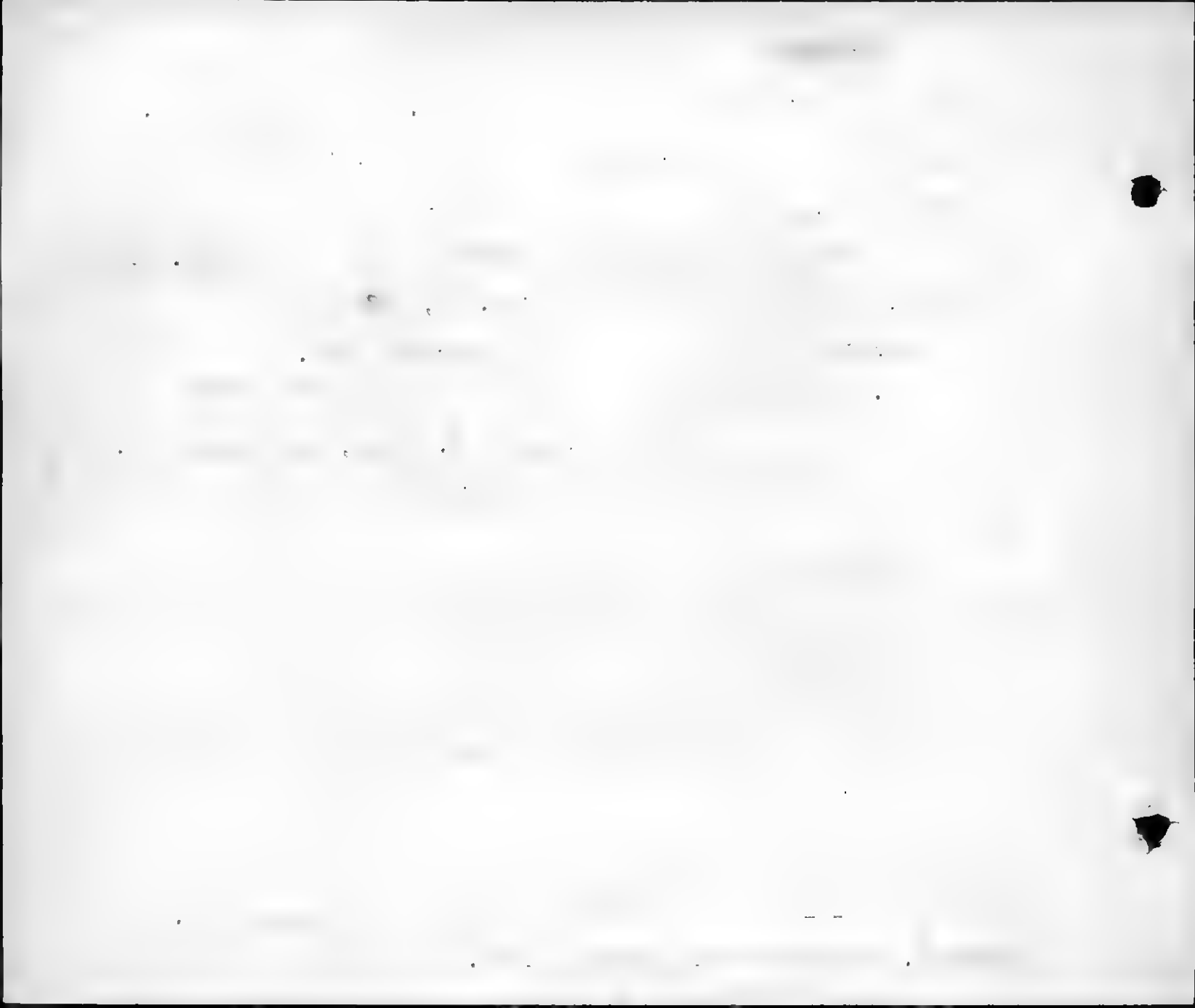


I

Reg. Dist. No.

10791

1. PLACE OF DEATH o. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Md.		b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b 3 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home		d. STREET ADDRESS RFD 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Luella Elizabeth Unger		4. DATE OF DEATH Sept. 5, 1960		Month Sept. Day 5 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873 Aug. 14, 1874	9. AGE (In years lost birthday) 87	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.	
13. FATHER'S NAME J. Leonard Vogel			14. MOTHER'S MAIDEN NAME Amanda Sigler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Leonard W. Unger, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis 1150.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro, Md.	
20f. (City or town) Boonsboro, Md.		20g. (County) Ind.		20h. (State) Ind.	
21. I certify that I attended the deceased from Jan 10, 1960 , to Sept 5, 1960 , that I last saw the deceased alive on Sept 2, 1960 and that death occurred at 11 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. Unger M.D. Boonsboro, Md. DATE SIGNED 9/6/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-8-60		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	
22d. LOCATION (City, town, or county) Smithsburg, Md.		22e. (State) Ind.		22f. (Country) Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		23a. REC'D BY REGISTRAR SEP 9 '60		23b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10790

10792

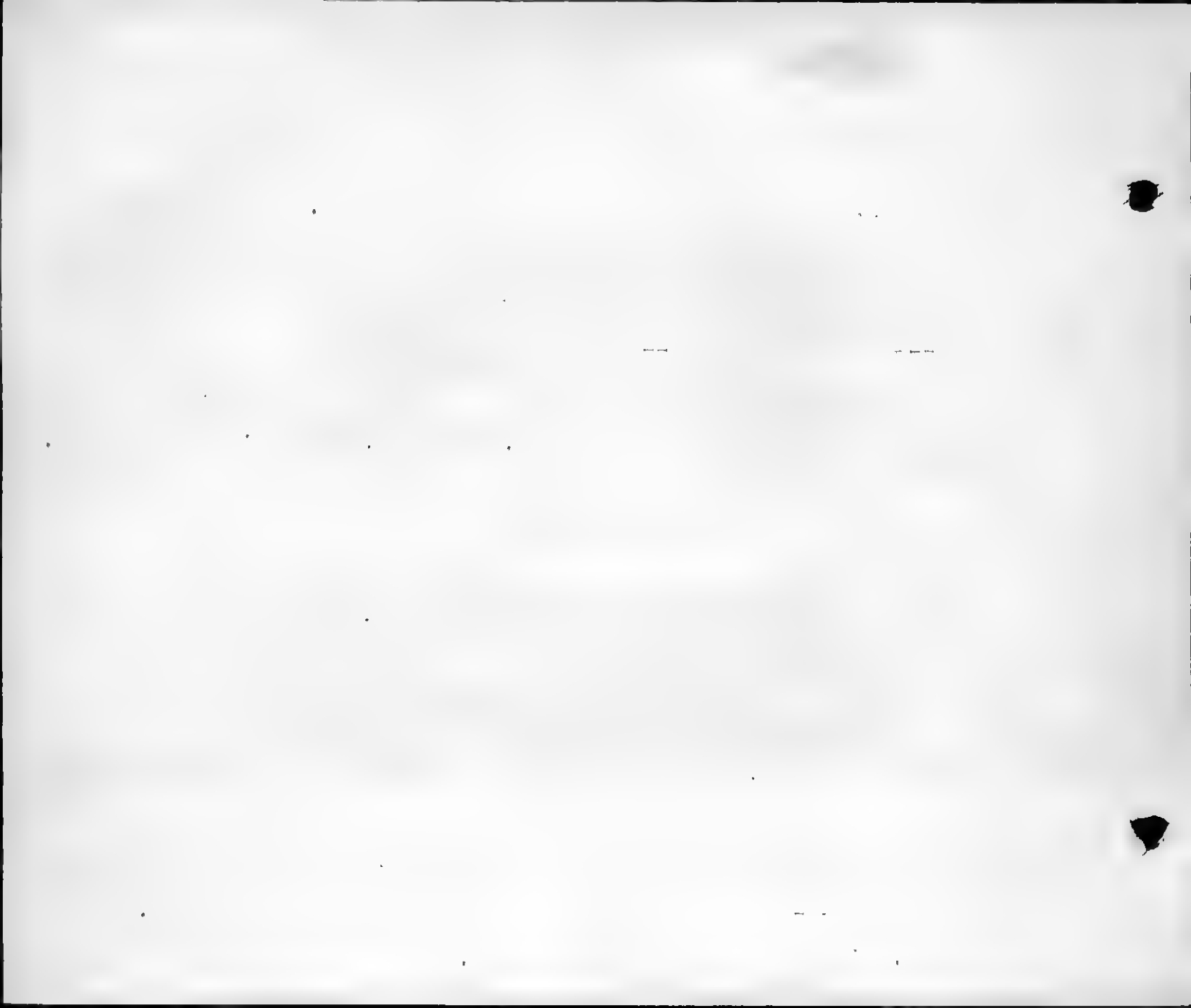
Items 11, 12 filed 9-19-60 et

10790

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Maizie Myrtle Vance				4. DATE OF DEATH Month Sept Day 8 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1884	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Unknown Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Vance				14. MOTHER'S MAIDEN NAME Katherine Shadrach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Carrie J. Vance Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rt. coronary occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis DUE TO (c) zink poisoning						INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old posterior myocardial infarction @ CVA & hemiparesis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21, 1960 , to Sept. 8, 1960 , that (I) (we) last saw the deceased alive on Sept. 8, 1960 , and that death occurred at 9:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos, M.D.				22b. DATE Sept. 8, 1960		22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.	
22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

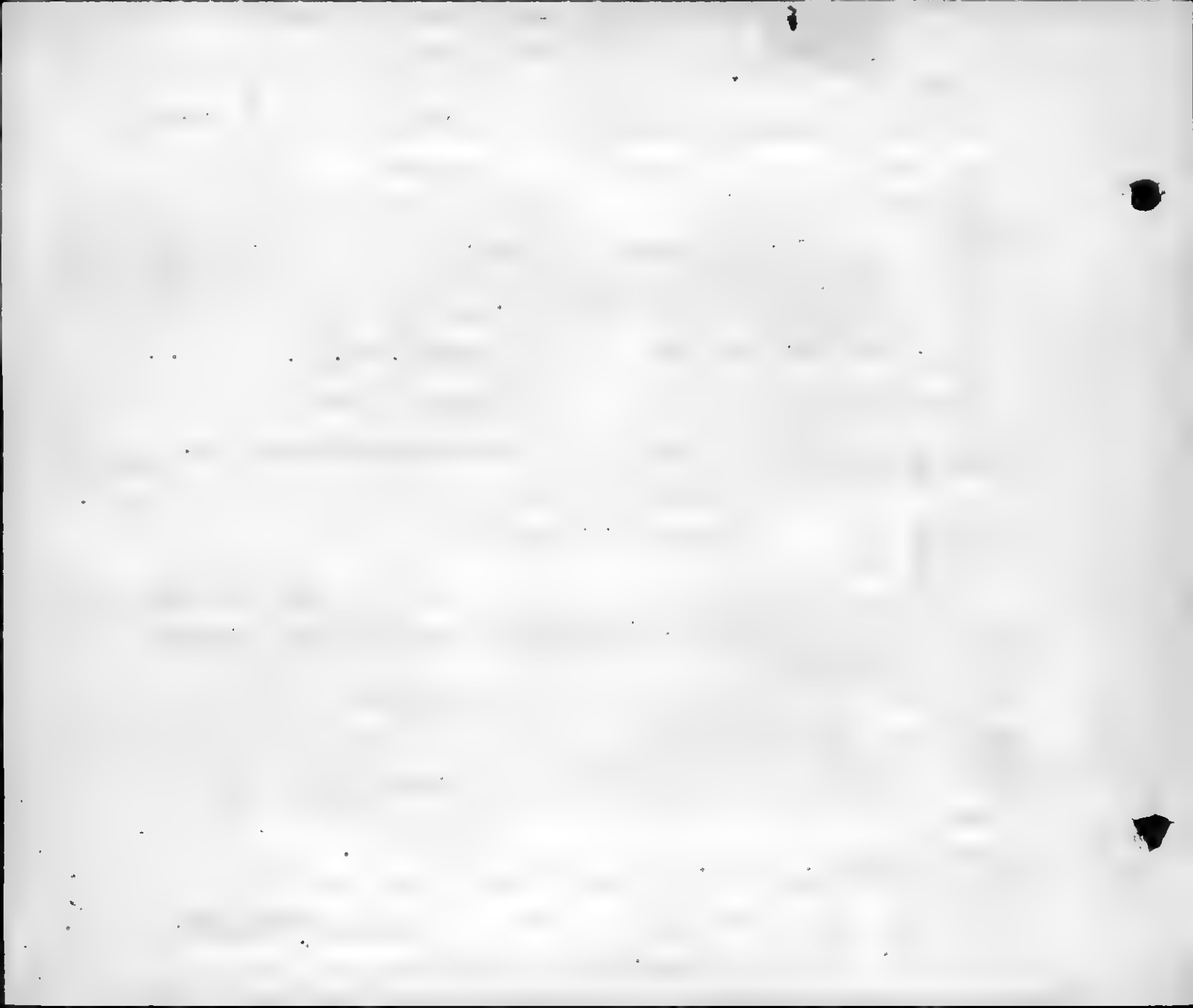
10791

CERTIFICATE OF DEATH

10793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>10dys /</u>		d. STREET ADDRESS <u>144 N. Popomac Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Alice</u> Middle <u>Weagley</u> Last <u>Wagner</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Operator Speciality Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cavetown, Wash. Cty, Md/</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Weagley</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Winters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Louise Weagley, Middletown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis, pelvic</u> DUE TO (c) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous cell carcinoma, right lung with recurrent pleural effusion</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u> </u> Day <u>19</u> Year <u> </u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 7th</u> , 19 <u>60</u> , to <u>Sept. 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 16</u> , 19 <u>60</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Kehne M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>131 W. Washington Street</u> <u>Sept. 17, 1960</u> <u>Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Kehne M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Cty, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u> </u>	



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10792

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10794

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS Williamsport R#2	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Ellen Nettie Watkins		4. DATE OF DEATH Month Day Year Sept. 17 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1907
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther M. Stoner		14. MOTHER'S MAIDEN NAME Anna L. Metzger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank F. Watkins Address R#2 Williamsport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 - 1 DUE TO A.C. Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/17/60 to 9/17/60 , that (I) (we) last saw the deceased alive on 9/17/60 , and that death occurred at 3:00 PM on the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young M.D.		22b. DATE SIGNED 9/18/60	
22c. PHYSICIAN'S NAME (Type) Ralph F. Young M.D.		22d. ADDRESS 101 E. Potomac St. Williamsport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE OF DEATH 9/21/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 21 '60	
		25b. REGISTRAR'S SIGNATURE Catherine L. Hume	

Wm. C. Hest



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10793

10795

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Earyl Middle G. Last WATSON				4. DATE OF DEATH Month 9 Day 1 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21 1882		9. AGE (In years, last birthday) yrs 78	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METER TESTER				10b. KIND OF BUSINESS OR INDUSTRY MUNICIPALITY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES M WATSON				14. MOTHER'S MAIDEN NAME ANNA BRENNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-34-0753		17. INFORMANT MISS HELEN B WATSON Address HAGERSTOWN MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobular Pneumonia 182-1 DUE TO (b) Bronchogenic Carcinoma of lung 6 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Bronchiectasis, Right lung							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, Right lung							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from June 9, 1960 to Sept. 1, 1960 that (I) (we) last saw the deceased alive on Sept. 1, 1960 and that death occurred at 11:45 AM from the causes and on the date stated above.							
22a. SIGNATURE Young E. Chun				22b. DATE SIGNED Sept. 1, 1960		22c. PHYSICIAN'S NAME (Type) Dr. Young E. Chun	
22d. ADDRESS 1500 Penn. Ave Hagerstown, Md							
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/3/60		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hager				25a. REC'D BY REGISTRAR SEP 6 '60		25b. REGISTRAR'S SIGNATURE Charles E. Hager	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10794
10796
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS 517 Greene Street	
3. NAME OF DECEASED (Type or print) John Lawrence WAYS		4. DATE OF DEATH Month 9 Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1897
9. AGE (In years last birthday) yrs 63		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype operator- Cumberland Times		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Ways		14. MOTHER'S MAIDEN NAME Barbara Wiegand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-4913	
17. INFORMANT Mrs. Edith A. Ways		Address 517 Greene Street, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO (b) glioma, left hemisphere DUE TO (c) ever/year		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Atrial fibrillation		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 28, 1960 to Sept. 4, 1960 that (I) (we) last saw the deceased alive on Sept. 4, 1960 and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED Sept. 4, 1960	
22c. PHYSICIAN'S NAME (Type) Young E. Chun		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/7/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR DATE SEP 7 '60	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

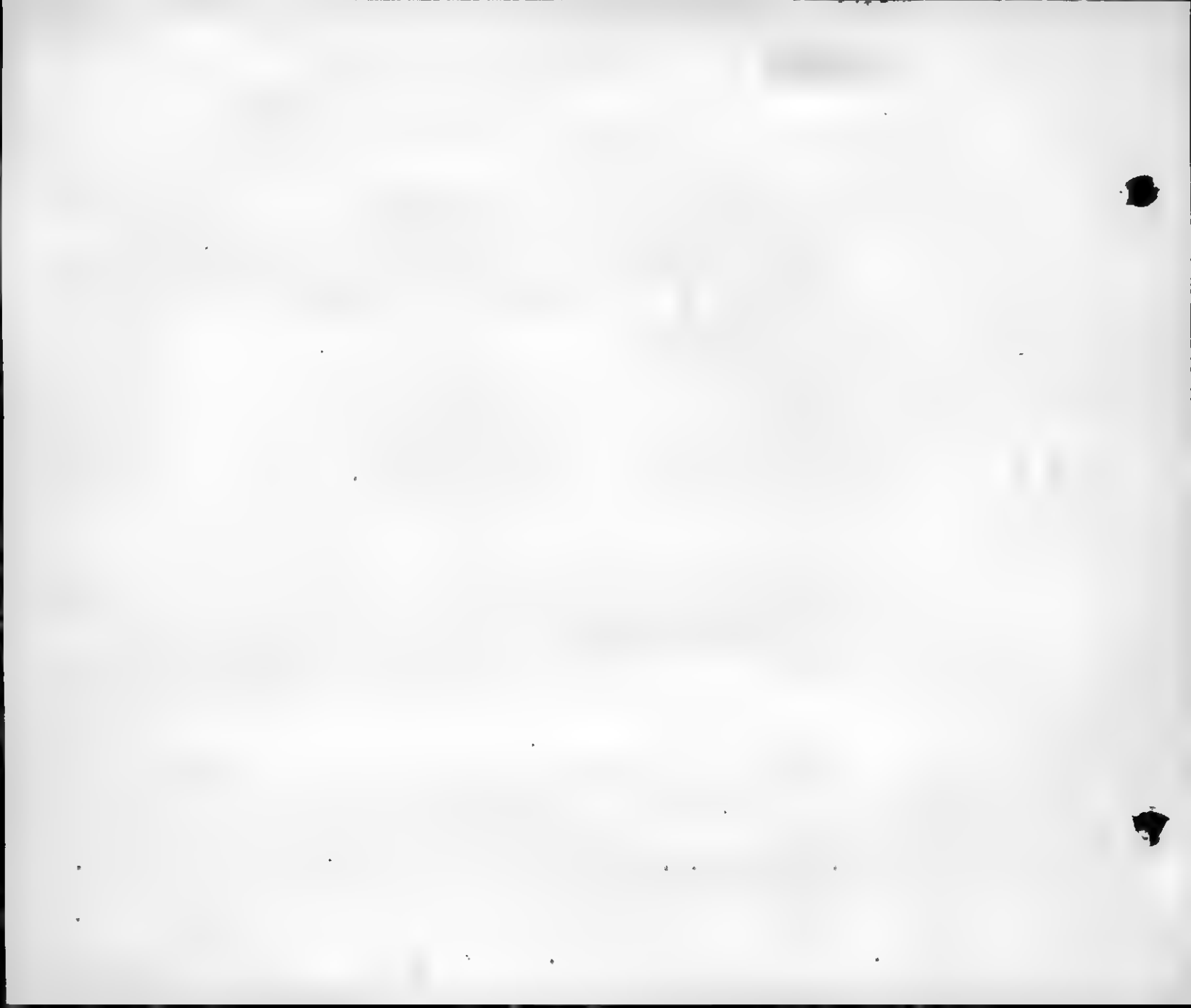
10795

CERTIFICATE OF DEATH

302

10797

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 Mulberry Ave		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1801 Mulberry Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) ALLIE May WELTY		4 DATE OF DEATH Month September Day 22 Year 1960				
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 15 1879	9 AGE (In years lost birthday) 81 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11 BIRTHPLACE (State or foreign country) Paramount Wash Co Md		12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME William Lohr			14 MOTHER'S MAIDEN NAME Barbara Clopper			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. None		17 INFORMANT Miss Leola Lohr		Address 801 Mulberry Ave
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ (County) _____ (State) _____
21 I certify that (I) (this hospital) attended the deceased from 3-20-1951 to 9-23-1960 that (I) (we) last saw the deceased alive on 9-23-1960 , and that death occurred at 11 A.M. from the causes and on the date stated above.						
22a SIGNATURE Dalton M. Welty		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9-23-60		
22c PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		22d. ADDRESS 998 Rtomac Ave., Hagerstown, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 9/24/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.
24 FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a REC'D BY REGISTRAR SEP 26 '60
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

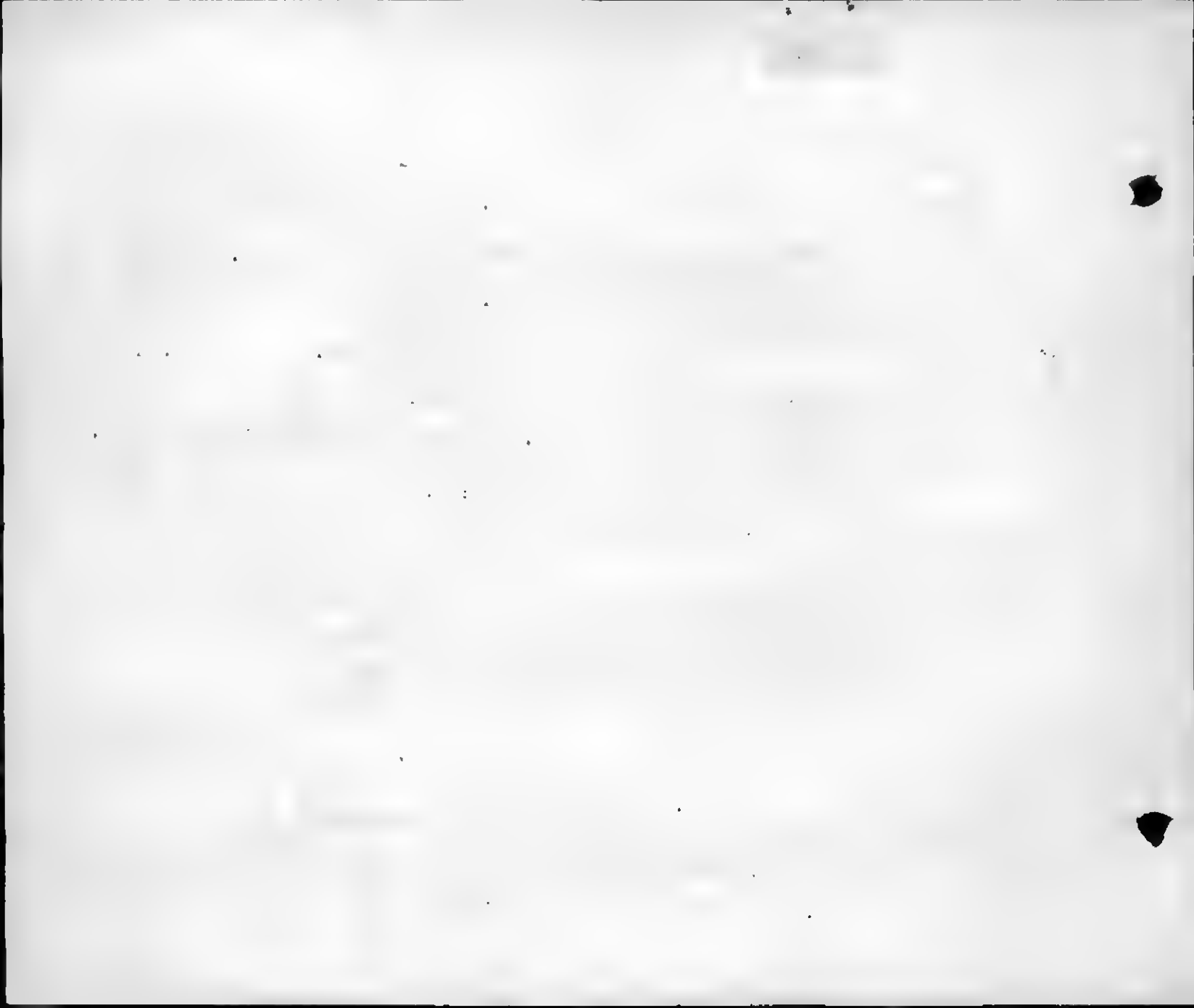
VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10796
CERTIFICATE OF DEATH

10798

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md (Rural) RFD #1			
f. STREET ADDRESS Williamsport Md RFD #1				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ronald Jay Whipp				4. DATE OF DEATH Month Sept. Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22 1960	
9. AGE (in years last birthday) yrs 8		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min. 8		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Charles Whipp	
14. MOTHER'S MAIDEN NAME Phyllis Whittington		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles Whipp Williamsport Md. RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Respiratory arrest 156.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity + Esophageal atresia DUE TO (c) 5 days				INTERVAL BETWEEN ONSET AND DEATH 2 min 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-ob weekness				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-22-60 to 9-30-60 , that (I) (we) last saw the deceased alive on 9-29-1960 , and that death occurred at 7:15 M, from the causes and on the date stated above							
22a. SIGNATURE M.E. Byrkit				22b. DATE SIGNED 9-30-60			
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit				22d. ADDRESS 28 W Potomac Wmpt Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 2 1960		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ormal Sutton Williamsport, Md				25a. REC'D BY REGISTRAR OCT 3 '60		25b. REGISTRAR'S SIGNATURE William S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

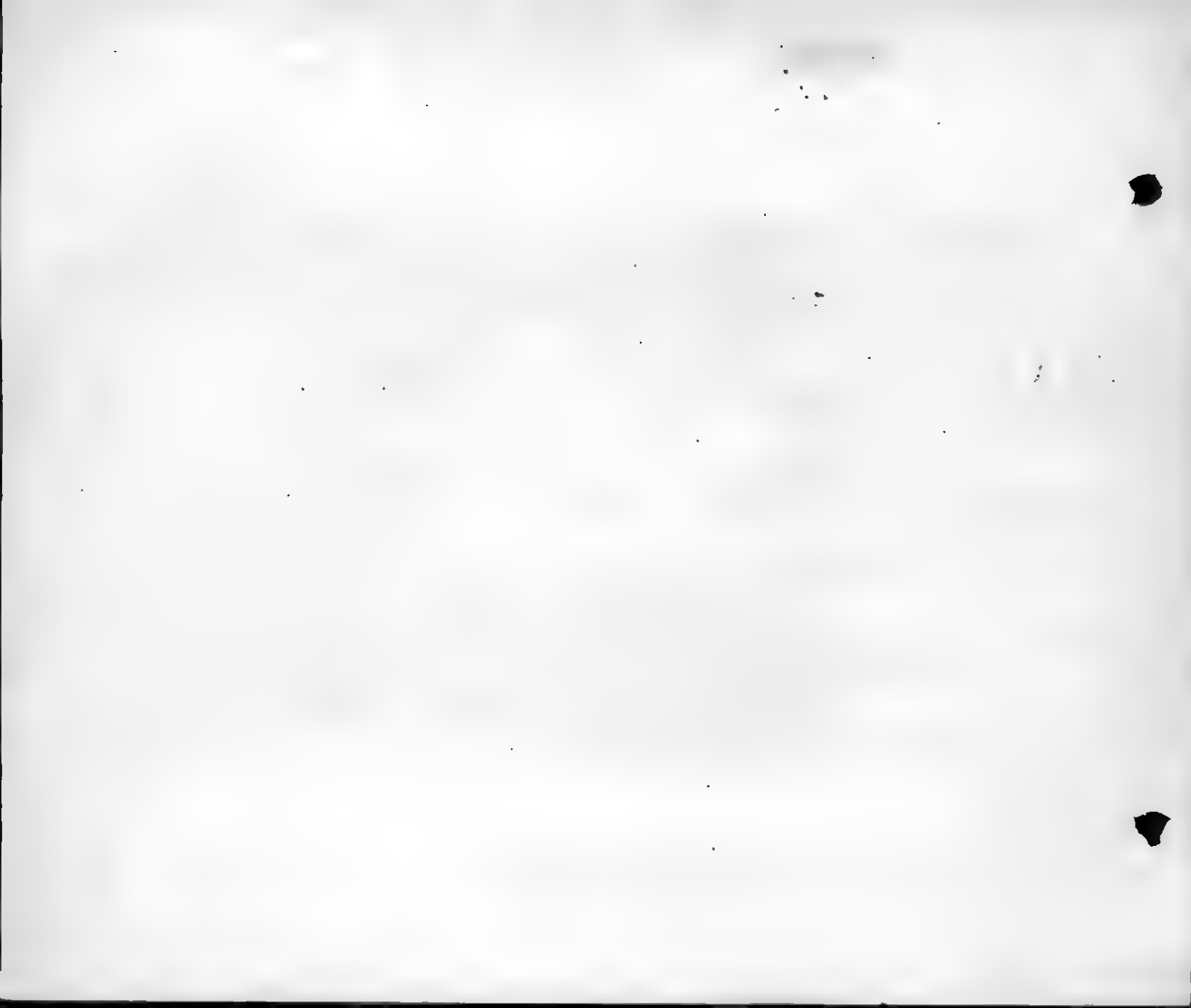
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10797

CERTIFICATE OF DEATH

10800

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patricia Ann Wolff</u>		4. DATE OF DEATH <u>September 2 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 6 - 1956</u>
9. AGE (in years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR <u>4</u> Months <u>26</u> Days <u></u> Hours <u></u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NO RECORD</u>		14. MOTHER'S MAIDEN NAME <u>NAOMI VIRGINIA WOLFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MERUE CLIPP</u>		Address <u>KEEDYSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypogammaglobulinemia</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Pneumonia - Viral</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Life</u> <u>1 week</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 2 1958</u> to <u>Sept 2 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 1 1960</u> , and that death occurred at <u>2 15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>G. W. Helvan</u>		22b. DATE SIGNED <u>Sept 4 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Helvan</u>		22d. ADDRESS <u>Boonsboro Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>SEPT 4 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO WASH. CO. MD. CEMETERY</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	
ADDRESS <u>1300RSBOKO MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kneass</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10801

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL (D.O.A.)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 428 Belvedere Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last YOST		4. DATE OF DEATH Month SEPT. Day 30 Year 19 60		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5 1907		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 9 Days 25		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Principal				10b. KIND OF BUSINESS OR INDUSTRY Public School Education				11. BIRTHPLACE (State or foreign country) Mc Dowell, W. Va.				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Rev. L. D. Yost				14. MOTHER'S MAIDEN NAME Elizabeth Neff															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Marguerite M. Yost (Wife) Hagerstown, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Atherosclerosis, Severe (c) Coronary Atherosclerosis, Severe DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 5 min. Recent							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9/30/60			
EXAMINER'S NAME (Type) H. K. Brown				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 3, 1960				22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery				22d. LOCATION (City, town, or county) (State) Shepherdstown, West Va.			
23. FUNERAL DIRECTOR'S SIGNATURE H. K. Brown								ADDRESS Martinsburg, W. Va.				24a. REC'D BY REGISTRAR OCT 4 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: (Faint text, possibly "JOHN J. ...")
2. Age: (Faint text, possibly "45")
3. Sex: (Faint text, possibly "Male")
4. Race: (Faint text, possibly "White")
5. Date of Death: (Faint text, possibly "Nov. 1, 1925")
6. Place of Death: (Faint text, possibly "New York City")
7. Cause of Death: (Faint text, possibly "Heart Disease")
8. Manner of Death: (Faint text, possibly "Natural")
9. Signature of Medical Examiner: (Faint signature)
10. Date of Certificate: (Faint text, possibly "Nov. 1, 1925")

NOV 2 1925

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be returned to the hospital. **ATTENDING PHYSICIAN:** This certificate should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. **NOTES:**

EXHIBIT 100-100000

100-100000

100-100000

100-100000

100-100000